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ATTITUDES IN PSYCHIATRIC ACTIVITY THERAPY

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WALTER G. KLOPFER, Ph.D.**

INTRODUCTION

This article describes a questionnaire concerning staff attitudes toward methods of dealing with problems arising in activity therapy in a psychiatric setting. Various uses and potentials of this tool are described and results of a preliminary study using it are discussed. In essence, questionnaires of this type might serve the following purposes:

1. An attitude and opinion measuring device.

Questionnaires of this nature may sometimes tell us something of the attitude and beliefs of therapists about their work.

2. An educational device.

A questionnaire may provide focus for classroom discussion about many staff-patient problems.

3. A way of measuring one's teaching effectiveness.

Questionnaires may help evaluate success in conveying ideas and concepts about patient care.

BACKGROUND

The seven situations comprising the questionnaire were originally designed to evaluate success in conveying a point of view to a group of activity therapy aides. A teaching program for these workers was developed in a psychiatric institute for the state hospitals of four states.

Briefly described, it called for a program consultant to spend a few weeks in each institution observing practices and ascertaining the educational needs of workers on the activity therapy service. Informal classes were conducted to fill the observed or reported gaps in knowledge about basic psychiatry, the role of activity therapy in the institution, and to seek solutions to daily practical problems. Because this was the first time such a training program had been given, because there were no guides or standards to follow, and because there were no other objective criteria by which the group's achievement might be measured, the consultant designed a questionnaire toward the end of the four weeks at the first hospital in which the program was conducted. These questions were designed to determine whether certain ideas had been successfully conveyed to the group. It was also to be used as the basis for a summary class discussion. Later, the material was analyzed in other ways which will be described below.

About two weeks after the original use of the questionnaire, the sponsoring institution had a workshop in occupational therapy which was attended by about 75 people. This group included registered therapists, and occupational therapy aides without professional training from various institutions in five states. The discussion at the workshop unearthed some diversity of opinion among participants about problems which were similar to those included in the questionnaire. There was also speculation about whether the diversity of opinion was a reflection of the range in educational level of the group, i.e., whether the professionally trained would tend to differ from the untrained participants in their answers to a questionnaire. To investigate these questions, two more discussion questions and a short series of information items, like education, experience, etc., were added to the original questionnaire. It was decided to distribute the expanded questionnaire on the second day of the workshop, after a brief introduction. The results formed the basis for the analysis presented in this paper.

When the replies of the workshop participants

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had been analyzed, the results were not what some had predicted. No interpretation seemed possible, however, without some consensual validation. Would other professionally trained and psychiatrically oriented people agree with the answers designated by the authors as "most nearly correct"? Were the questions objective in any sense or did they merely reflect an individual point of view, and possibly personal prejudices? How much consensus about them would there be among "experts."

These questions have not been answered conclusively, but the results of administering the questionnaire to a small group of professionally trained people are also presented.

CONTENT AND ANALYSIS OF THE QUESTIONNAIRE

Before describing the results, it may be well to examine questions asked and the purposes for which they were designed.

Directions for Questionnaire

Here are seven stories. Please read them and check the answer that you consider most nearly correct. Please answer the way you really think . . . not the way you think I think.

IT IS NOT NECESSARY TO SIGN YOUR NAME TO YOUR PAPER

Question 1.

Four patients are working together assembling the newspaper. You know very little about their problems and background. They get into a heated difference of opinion on how to proceed. The loudest of them is a patient who is frequently in arguments. One of the patients is a very withdrawn person and he seems to be upset by the argument. Another patient who is usually conscientious seems to be ignoring it all. The last patient seems to be really anxious to get the job done by four o'clock, the deadline. You know too that all the other patients on the ward are waiting for the paper. The argument seems to be stalemated.

What would you do?

a. Take aside the patients that seem to need extra help in handling the situation. For example, comfort the disturbed patient, and try to quiet the noisy one.
b. Try to avoid further difficulty by changing the subject to something more pleasant, in the meantime working along with them to set a good example.
c. Join the discussion and try to clarify the issues at hand.
d. Since the hospital is a place for people to find out how to get along with each other, leave them alone to puzzle through the problem by themselves, as it is their problem.
e. None of these, I would—

Why did you choose the answer you did?

Discussion on Question 1. A deceptively simple and ordinary occurrence is used to illustrate many principles. These principles are analyzed in a decision making setting. The most obvious choice which must be made in this illustration is between making peace by diverting attention from the conflict (b) or permitting the conflict to continue (c and d). Another choice is how active a role a therapist might play in resolving his conflict (a, b, or c, versus d). A third is whether to approach the problem from the point of view of the entire group (b, c, or d) or whether to seek solution through individual handling of group members (a). And finally, the choice must be made between efficiency in accomplishing a task whose completion it is suggested may benefit the entire patient group (b) or dealing most effectively with the group at hand (c).

Given the following orientation the "c" answer comes closest to being most nearly correct. First it is more beneficial to teach patients to analyze and employ conflict constructively than to seek mere serenity. Second, active patient participation in therapeutic processes may provide solutions more effective than those handed down from above. Third, the goal is to help patients, rather than accomplish a task.

Question 2.

Mrs. Smith has just started making her one hundred and tenth rug on the loom (same pattern). She is a middle aged woman who has been hospitalized three years. You know she is intelligent and you feel that she could do more advanced work, that would give her more satisfaction. In the past other OT's have tried to show her other work, and interest her in a change. She looks at the other work as though she were afraid of it.

What would you do?

a. One hundred and ten times is too much for a woman of her intelligence to do such a simple task. The therapist must make the decision for Mrs. Smith, because though she would like to make the change, she is not yet able to make the decision for herself. She will be grateful later on that the therapist helped her to a more suitable activity.
b. The patient understands best her own needs, and if this activity gives her a feeling of security, then let her continue to do it, until she can afford to give it up of her own free will.
c. Join the patient each day when she works and see if she can tell you what the weaving means to her, and what her own hopes for herself are, before you make any decision.
d. None of these, I would—

Why did you choose the answer that you did?

Discussion on Question 2. Even as simple a situation as this where the therapists' only alternatives are to do something (a), to do nothing (b), or to wait and see(c), has ramifications which go beyond the particulars. Should therapists set goals for their patients? Should they decide what is good for patients? These are the theoretical questions illustrated in the example. The choice of the third alternative is contingent on a negative answer to the questions raised by the story. Having decided that a therapist should not impose his own goals, but should seek to understand and assist patients to find reality and achieve their appropriate objectives, "c" is the most nearly logical procedure.

Question 3.

A patient who is very psychotic and uncommunicative wants to go through material at a great rate. She is painting now, poster paint on large sheets of manila paper. She wants to take some of the unbleached muslin (that is used for tea towels) and try copying some of her very odd designs onto it with scrap wool. You've never seen anyone try anything like it, but you can almost predict that she will not succeed in making anything but a big mess.

a. Explain to the patient that we have a limited budget, and that you cannot allow her to waste materials. Gently try to lead her to another more sensible activity.
b. Join the activity with her, and "mess" right along side of her. In this way you will get the spirit of it, and the patient will see that you understand her.
c. Let the patient do the activity. Perhaps she can tell you through the activity what it is all about.
d. Since the patient is so uncommunicative and will neither talk to or listen to you, it is best to let her proceed without interference.
e. Try to get her to do a more useful activity. A hospital should help patients to behave more normally, and making useful and sensible projects is one way to achieve this.
f. Ask her to explain to you what she is doing and if she cannot, that means that she is too confused to be allowed to make such decisions independently.
g. None of these, I would—

Why did you choose the answer that you did?

Discussion on Question 3. This situation brings to the fore and presents, in a slightly different light, a component of both the previous ones. In the first story the therapist had to decide whether he was going to impose his kind of resolution to a quarrel. In the second, he again had the choice of stopping or continuing an activity he considered undesirable. The same kind of choices are involved in this example, except that the patient described is clearly psychotic and irrational and the possibility of talking out a solution is probably barred. Again, however, the more therapeutic approach is deemed to permit behavior which may be considered undesirable (b, d) rather than strive for surface normalcy (a, e, f).

The distinctions between permitting, but not accepting psychotic behavior (d), permitting and accepting it (c), and going beyond that to encouragement are clear. The first alternative would not provide the nonverbal communication which might increase therapist efficiency and understanding.

Whether "c", which is permissive, or "b", which goes beyond that toward encouragement, is the better solution rests with the particular therapist, his personality and his relationship with the patient. With the provision that "b" comes easily and naturally and that time is not a limiting factor, it and "c" are the two answers which come nearest to fulfilling the therapeutic goals described previously. Either answer, then, was considered to be correct.

Question 4.

A new patient comes into OT who doesn't know the way of this hospital. As a matter of fact this is his first hospitalization anywhere. He suggests a new way to do something that involves others. (Like a change in the coffee hour.) Most of the patients don't say too much about it. Six patients think this is a good idea. Two old-time patients say that they don't want to see any change. "We've been doing it this way a long time and no one else found anything so wrong with the system." The new suggestion involves more work for you indirectly and you are already fairly busy. It involves a great deal more work for the patients, but they do not seem to mind at all. Aside from this it seems like a reasonable suggestion, but you are not sure what it will lead to.

What do you do?

a. You tell the patient that it seems like a good idea and that he should hang onto it and wait a few months until he learns the way of the hospital better.
b. You do nothing, leaving the group to handle the situation.
c. You gather together all the interested people (both pro and con) to see how workable the suggestion is in preparation to trying out the new suggestion for awhile.
d. You explain the working of the hospital to him, realizing that people come to the hospital because they have been having difficulties in getting along on the outside, and you feel that his recovery depends on how well he adjusts to the hospital as it is.
e. None of these, I would—

Why did you choose the answer that you did?

Discussion on Question 4. Like the first illustration and as distinguished from the other two, this permits the choice of handling a situation with an individual (a or d) or with a group (b or c). Unlike the first, however, the therapist choosing to work with a group has the additional choice of taking active steps to structure the situation in which the group operates (c) or merely permitting any existing group forces to operate (b). The choices involved in dealing individually with the patient also raise a question about the desirability of encouraging conformity on his part (d and more subtly a). This involves again, though less directly, some decision about whether the patient or the hospital operating routine comes first. Those who believe that patients' needs might come first and, in addition, see value in employing principles of group dynamics would select the "c" resolution.

Question 5.

A new OT aide has just come on duty and you are to help her out the first few weeks answering her questions and helping her adjust to the job. The new aide very quickly warms up to a patient named Mrs. Jones. Mrs. Jones is a very dependent woman, and has been having a great deal of difficulty with her project. She is very happy to have the new aide's full attention. The new aide says that Mrs. Jones reminds her very much of an old school friend that she knew very well. You notice that the new aide spends almost all her time with Mrs. Jones and is not giving the other patients as much time as you think they need. The new aide points out

to you that Mrs. Jones really needs her help much more than any other patient.

What do you do?

a. Explain to her that all patients need her help, and suggest that she divide her time evenly among the patients.
b. The new aide is obviously over-involved with the patients, and it is important to avoid this. Therefore, Mrs. Jones should be assigned to work with another aide.
c. You discuss with the new aide the problems of over-identification and help her to understand what there is about this patient that is so engrossing, and try to get her to realize that the other patients need her also though they may show it less.
d. You encourage her interest in Mrs. Jones because it is very good that she shows Mrs. Jones that she likes her, and has the ability to have a close and warm relationship with patients.
e. None of these, I would—

Why did you choose the answer that you did?

Discussion on Question 5. Therapists have become increasingly concerned about the nature of the relationship between themselves and their patients. Many have come to believe that this relationship holds the clue to what is or may be therapeutic in an activity program. Interest has therefore been focused on problems in relationship. Should the therapist attempt to remain uninvolved, objective or distant? If it is desirable to remain uninvolved, is it possible? Schwartz and Shockly[1] state that involvement is inevitable, but that in order for it to be helpful, both staff and patient needs must be recognized and dealt with in appropriate ways. If we say that involvement is beneficial the first two answers (a and b) would be discarded. Then the search for the most clearly correct answer (c or d) requires understanding on the part of the therapist that he, like everyone else, has motivations of which he is sometimes unaware.

A "d" answer has merit only if one could assume that patients' needs are being considered here, in addition to the staffs', and if the story made clear that the aide did not have responsibility to other patients. For an aide who has not yet developed the kind of self-awareness about patient involvement which has been described and who has not yet learned to balance group and individual needs simultaneously, the most nearly correct reply is "c".

Question 6.

A very delusional patient comes into the shop one day with something he has written and gives it to you. In it he expresses the belief that he has extra human powers . . . that he can see things that are taking place very far away. He has woven all this into a sort of "story" that is very difficult to follow. The doctors and others have mentioned that they have tried to read his stuff too, but they couldn't make head or tail out of it.

What do you do?

a. You read the story and try to understand it . . . then discuss it with him pointing out how illogical it is. Help him understand that these things cannot be and in this way he will get better.
b. It is not your business to look at his personal writing, so you immediately send it to his doctor to file it in his clinical chart without reading it.
c. Since everyone has listened to this man for so long, there is no point in your getting involved in it and you dispose of the material in any way. Getting involved in it will only upset him more than he is already.
d. Enter into the delusions with him, pretending that you believe he has these powers, and ask him to get some information for you from your home.
e. Accept his writing, read it and discuss it with the patient if he chooses to do so.
f. Accept the writing, acknowledge it, read it and tell his that you understand how he feels, but you cannot accept his reasoning or logic.
g. None of these, I would—

Why did you choose the answer you did?

NOTE: (One phrase was omitted from choice "f" by error, it should read: "but refuse to discuss it with him." For this reason, choice (e) and (f) look very similar.)

Discussion of Question 6. As in Question 5, this story deals with therapist-patient involvement, though this is a first hand rather than second hand experience.

The question asked here is how much and what kind of participation one can indulge in when dealing with very irrational behavior or ideas.

Extreme noninvolvement is illustrated in "b" and "c". Intense involvement and participation in the psychosis is illustrated in "d". Acceptance which is a start toward involvement is shown in varying degrees in "a", "e", and "f".

Once a therapist decides to understand and accept a patient's illness, he must decide what to do about it. He faces a choice of trying to ask a sick person to behave in a way that he considers to be healthy or normal (a), or permitting the patient to express symptoms of his illness. These latter choices which are considered here to be more beneficial involve shades of difference. The first is deemed more accepting and permits more latitude for learning to understand patient's behavior. Though less explicit than "f", it is preferred.

Question 7.

A new patient comes into the shop that you know very little about . . . only his name and his ward number . . . But you can see he is an expansive, energetic and aggressive looking man. He quickly announces that he will make an elaborate tooled wallet with a rather intricate pattern. He says he knows how to do it, and doesn't need any help, just the tools. This is a hospital where patients pay for their supplies and he can well afford the small sum involved.

What would you do?

a. Fine leather work is not a good activity for such an aggressive person and you do everything you can think of to get him to an activity you consider more appropriate.

Number of "correct" answers		CORRELATION	LEVEL OF SIGNIFICANCE
	Registered OT's	Biserial R. Correlation Coefficient = .51	.01
	No. of years of education	Pierson Product Moment Correlation Coefficient = .42	.01
	College graduate but not OTR	Biserial R. Correlation Coefficient = .40	.01
	No. of years experience	Pierson Product Moment Correlation Coefficient = —.22	.05

Chart A. Correlation of Answers

b. You give him the tools and see how he makes out. After all your first impressions of people are often misleading and when we get to know him better, we may discover that this patient knows his own needs in this case.

c. Since you are the therapist, the patient is not the one to make these decisions. After all this isn't just a hobby shop and you know what is best for him to do. You explain this to him hoping he will accept it.

d. You send him back to the ward saying that when he is better able to work with us, he can return to OT.

e. None of these, I would—

Why did you choose the answer you did?

Discussion on Question 7. The last story is an extension of previous ones. Again, as in Question 2 and 3, there is a situation in which a therapist may feel that he has knowledge, ability and authority to determine what is good for a patient. If he employs these, he chooses any alternative but "b". For reasons previously dicussed, however, "b" is considered most nearly correct. That is, if it were true that leather work is bad for expansive, aggressive patients, it might be better, even so, to let the patient discover this for himself. If it were true that leather work is not suitable for 98% of patients like this one, he might be among the 2% for whom the activity is beneficial. Furthermore, there is no such unanimity of opinion about the effects of activities on behavior or illness and there is some question about whether it is possible to have the "knowledge" implied in the other alternatives. Finally, people are always much more than the sum of their symptoms and the therapist has the opportunity of acquiring new insights about the patient if he chooses the "b" alternative.

THE EXPERTS

In order to evaluate the consistency of judgment concerning the preferred alternatives, answers were obtained from seven people. These included: two psychiatrists, three psychologists, one occupational therapist, and one group worker. All "experts" got all questions correct. They have these traits in common: they are influenced by some contemporary school of dynamic personality theory, they are interested in behavior and unconscious motivation and they have clinical experience in mental hospitals. It should be perfectly clear that none of these seven people represents anyone but himself. They are not a sample of any larger group. Even granting selectivity designed to seek experts with whom the authors find themselves in agreement, the unanimity on every question seems impressive enough to indicate that the questions do more than reflect an individual or idiosyncratic point of view. Memory of quite heated discussion and decided disagreement in point of view about many aspects of therapy with some of these "experts" ruled out the possibility that they had failed to heed the note on the questionnaire. "Here are some stories. Please read them and check the answer you consider most nearly correct. Please answer the way you really think, not the way you think I think."

Finally, it should be added that the authors are sure that it would be easy to find seven or many more "experts" who would completely disagree with every answer which is considered "most nearly correct" here. They, however, would belong to a different school of thought and all

	A	B	C	D	E	F	None of these	
1.	3	21	**10**	1			9	— 8 + 1
2.	8	3	**20**				3	— 2 + 1
3.		**11**	**19**	1	4	1	4	— 3 + 1
4.	10	1	**27**	6			1	— 1
5.	6	1	**33**	1			2	— 1 + 1
6.	2	3	1		**17**	15	3	— 1 + 2
7.	13	**10**	6				13	— 1 +12

Bold face answers considered "correct."

Chart B. Scatter of Answers in Workshop Group

that the authors attempted to show is that there exists a school whose members find areas of consensus about the questions on the test.

METHODS AND RESULTS

Of the participants in the workshop mentioned above, 46 subjects successfully completed the questionnaire. Along with their answers to the questions described above, certain basic information was gathered to serve as the basis for further comparisons and data analysis. Respondents were asked to fill out the following form.

How many years of high school have you completed? .....

How many years of college have you completed? .....
If you went to college, what was your major? .....
Are you a registered occupational therapist? .....
How many years have you worked with psychiatric patients? .....

The score used as a basis for comparison consisted of the total number of "correct" answers to the seven situations depicted in the questionnaire. Judgments were made by the senior author on all the "None of those" answers, and they were then marked plus or minus. All plus answers were considered correct.

A significantly positive relationship was demonstrated between this score and the education of the subjects. This relationship existed when total years of education were considered and also when college graduates were compared to non-graduates. Also, it was discovered that registered occupational therapists as a group tended to do better on the questionnaire than those who did not possess this qualification. All of the above relationships were significant to the extent where the result could not have been achieved by chance more than once out of a hundred cases.

It was interesting to note that when scores on the questionnaire were correlated with years of experience in activity therapy, the relationship was negative although only of minimal statistical significance. In other words those who had more years of experience tended to do less well on the questionnaire, probably reflecting their lack of familiarity with the principles implicit in the questionnaire. This particular result was less significant than the ones cited above, as it could occur by chance in five out of a hundred cases.

Thirteen additional subjects all employed in a single institution had previously answered the questionnaire. Judgments were made by the senior author as to how effective these thirteen people were as therapists; they were made on the basis of five weeks observation. This provided the possibility of another sort of data analysis, making it possible to determine whether any relationship existed between work efficiency and sophistication as operationally measured by the questionnaire for the group as a whole. Interestingly enough the relationship was so highly significant that it could occur by chance no more than once out of a thousand times.

The Kuder-Richardson formula was used to test for internal consistency. This was to find out if subjects would respond to items in a consistent manner, and the replies did not represent some chance variation. In view of the small number of items on the questionnaire, this test on internal consistency demonstrated considerable reliability from item to item (See Charts A and B).

DISCUSSION ON RESULTS

In this survey, the number of "correct" answers were tabulated. No effort was made to weigh the explanation respondents gave for their answers. Therefore, a few people checked "right" answers for what were considered to be "wrong" reasons, and conversely a few people gave excellent justifications for what were considered "wrong" answers. For example:

(1) One respondent checked choice "e" in Question 1 because,

"As Florence Nightingale said, 'If you can win them, you may do what you will with them'."

In this case, it seemed that the respondent was aiming for eventual full therapist control, rather than helping the patients take responsibility for their own lives. The question was written to the latter point.

2. In answer to Question 5, another person checked "c"

(*Continued on page 268*)

A DYNAMIC THERAPY FOR SCHIZOPHRENIA[1]

DONALD L. SCHAEFER, M.D.[2]
JANE J. SMITH, O.T.R.[3]

The development of play as a form of therapy for children has had a long history, and the therapeutic effectiveness of this form of treatment for children has been well established. A play situation for treatment of adolescents and adults that have emotional pathology has been very little explored. The hypothesis that gratification of basic needs by symbolic realization, in some patients with severe emotional pathology, may result in better contact with reality has been reported by Marguerite Sechehaye[1]. Further research reported by Azima and Wittkower[2] has provided the conceptual framework for a dynamic treatment of schizophrenia in patients at the Milwaukee County Hospital for Mental Diseases with a play therapy technique that is based on symbolic realization.

The term "play therapy" is used here to describe the situation in which the attempt is made with regressed patients to utilize symbolic realization to fulfill their basic needs frustrated in infancy. In the conceptual framework used in the treatment of patients in this study, the main pathology appears to be withdrawal from, and a giving up of, the object world. When the first object relations develop in an insecure, frustrated infant, he may not succeed in creating positive and stable relationships with the world around him. With the onset of mental illness, he then adopts a narcissistic, regressive state of living. It is felt that this regression and withdrawal can be understood as a defense against anxiety arising from contact with objects. The anxiety is initiated and perpetuated by the expectancy of rejection and frustration. The individual relates external and internal objects and manifests aggression against them; this aggression is both projected and introjected, with interplay between them. Strong frustration, and consequent fixations probably occur at very early stages of development, resulting in ego impairment. The frustrations may be looked upon as lack of gratification of early oral and anal object needs.

Examples of frustration of oral basic needs may serve to illustrate this theory. Non-gratification of the sucking instinct, lack of nourishment when hunger afflicts the infant, or deficiency of tenderness and love in the mother for the child in providing nourishment, may frustrate the infant. The result of frustration is aggressive crying. Fearful of being aggressive toward his one love-object, the child may turn the aggression upon himself, with resulting guilt and anxiety. The patient regresses emotionally to the point of frustration, the fixation point is established and then repressed. It follows, then, that we are dealing with fixation positions of different qualities and quantities, depending upon the kind and amount of frustrations, and the guilt which accompanies regression. Shame and embarrassment usually accompany regression to the infantile level, which is resorted to only to seek the forbidden maternal love and protection denied in childhood.

In the treatment of the patient, we allow a deep but transitory regression to occur. Permissive regression and fulfillment of needs at the level of the regression overcome frustration; feelings of guilt and anxiety decrease, and the fixation position may be abandoned. We also find that the internal and external objects combine as progressive ego integration takes place.

This study was begun in July, 1956, at this hospital, and lasted for approximately one year. A total of twenty-eight female patients entered this dynamically oriented procedure; all of these patients had been diagnosed as catatonic schizophrenics. Twenty of these were adults; they were treated three times a week for seventy-five minutes in each session with an average of eight patients in the group at a time. Eight were adolescents, treated twice a week with an average of six patients in the group. Twenty-two of the patients in the treatment groups had had tranquilizing drugs and/or somatic therapies. Nineteen had prolonged hospitalizations with two or three admissions. Some of the patients were undergoing the commotion of their psychosis' active period, and acting out their regression; they were agitated and overactive, and established contact with objects very quickly, making their needs apparent and more easily satisfied. Others were quiet and content in their psychotic equilibrium; some were withdrawn; others insecure eager to gratify their needs.

The treatment team consisted of a psychiatrist and an occupational therapist and occasionally one or two observers who participated in the play activities. These figures symbolized the father, mother and sibling relationships. The

1. Read before Milwaukee Neuropsychiatric Society, May, 1957.

2. Resident in psychiatry, Milwaukee County Hospital for Mental Diseases, Milwaukee, Wisconsin.

3. Occupational therapist, Milwaukee County Hospital for Mental Diseases.

attitude of the treatment team was one of kind permissiveness; a sympathetic understanding approach was used, and the attempt was made to create a situation in which feelings could be expressed without guilt. The therapists tried to make the patients understand that they were interested in their thoughts and feelings and eager to gratify their needs.

The playroom measured about fifteen by fifteen feet. At the beginning of treatment the room was painted and curtains were added to the four windows. Tables and chairs were used initially, but later removed and small stools and rugs were added to sit and play on. Media for the gratification of anal needs and anal object relationships included plasticine, wet clay, sand, water, sawdust and finger paints; these were offered the patients in about this sequence. Increasingly structured objects such as dolls and doll furniture, teddy bears, blocks, musical instruments, mechanical toys, crayolas and coloring books, paper, children's literature, live fish and turtles were also present. House plants and religious pictures and articles were introduced to provide a home-like atmosphere. Oral needs were gratified by the use of milk in baby bottles when indicated and other liquids, suckers, gum, popsicles, cookies, fruit and popcorn. Hostility and aggression were released with pounding toys, drums, dried clay which could be broken, and beanbags thrown at figures drawn on the wall.

A typical session began with some of the patients being brought by attendants, others coming from open wards. After greeting the therapists and each other, they were offered suckers, candy or popsicles and an object to which they had become attached.

One patient formed a close attachment to two baby turtles which she requested to be fed each day. Soon after this interest developed, the therapist fed the turtles at the beginning of each session and watched them for a few minutes. Other patients played in the sand box constructing tunnels, houses, cakes or played with sand toys or small figures of horses and people. Socialization was fostered, and stimulation in the group furthered by playing ball. Dolls were bathed and dressed or simply cuddled by some. Some patients had needs satisfied by soaking their feet in a large pan of warm water; they sometimes added sand or sawdust to the water. One patient regressed from painting on the wall with finger paints to assuming a foetal position in warm water which resulted in much needed satisfaction. Before this the girl showed great anxiety during finger painting at which time she became excited, jumping up and reaching high on the wall and throwing paint. Later she was able to finger paint without anxiety and expressed no more desire to get into the water; we felt then that she had left a fixation position.

Halfway through each session the food was brought to the playroom and served by the therapist or patients, if they took the initiative. All birthdays were observed with a cake and presents.

The atmosphere of the sessions was one of permissiveness to the point where the patient could make contact with objects and act out as he wished. Destruction of objects was permitted, but patients were protected from bodily harm. Aggressive outbursts were rare.

We observed the patients to be secure in the playroom. Transference was observed, studied and worked through. Patients who had several months of treatment became more independent of the therapist and enjoyed more advanced activities such as playing cards and dancing with each other.

At appropriate times interpretations were made along psychoanalytic lines by the psychiatrist. We encouraged patients to fully verbalize their thoughts and feelings and support was given by one of the therapists when anxiety was noted.

Sessions ended promptly after seventy-five minutes. Patients were allowed to take particular objects to which they had become attached to the ward if they so desired. After the sessions, discussion and exchange of observations was carried on by the therapists, and plans made for further therapy.

Clinical results of this work have been encouraging. A number of patients have left the hospital. Some have found positions, others are making good adjustments at home. Some are making good adjustments in the therapeutic environment of the hospital. In evaluating our progress with the patients, we used the longitudinal study of the patient's history as a baseline, and the patient as her own control.

In carrying out this form of treatment, it is necessary to establish a patient-therapist relationship, to provide objects that are similar to the non-frustrating, mother-child relationship, to provide objects that are identical, similar or symbolical to the original needed infant object, and to encourage a transitory regressive state during which the patient can allow himself to gratify his frustrated needs. Patients seem to leave fixation positions after gratification of needs that have been frustrated. The transference with the therapists is a way their weak ego can gain strength.

We do not feel that this form of therapy provides a cure. It has, however, been of value in the treatment of severe emotional problems,

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THE STATIC NIGHT SPLINT

O. LEONARD HUDDLESTON, M.D., Ph.D.[1]
WILLIAM HENDERSON[2]
JOHN CAMPBELL, O.T.R.[3]

This is the fifth in a series of articles on bracing developed at the California Rehabilitation Center[4]. The static night splint is designed to hold the fingers and wrist in the neutral position.

THE OBJECTIVE

The objective of this brace is to provide prolonged traction on spastic muscles of the forearm and hand, and to stretch the fibrotic tissues of the hand and maintain optimal positioning of the thumb and fingers, preferably at night. Customary treatment for such disabilities usually consists of stretching soft tissues of the wrist and fingers for fifteen minutes twice a day, while the patient holds the wrist and fingers flexed the rest of the day and night, nullifying the beneficial effects of the treatment. It is felt that if the hand and fingers are held in extension for a considerable part of each twenty-four hours of each day (the eight hours of sleep, if possible) stretching of tight structures of the hand would provide a more effective treatment.

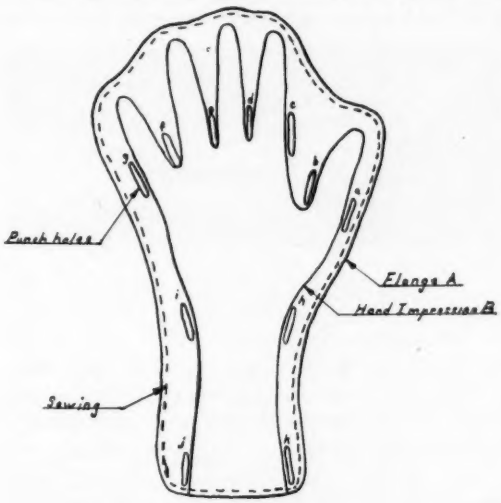

Figure I.

Although the hand is held in a relatively flat position in the brace, clinically, we have found very little tendency toward flattening of the transverse metacarpal arch or subluxation of the metacarpal phalangeal joints. However, when the patient demonstrates a tendency toward these deformities, pads of felt are sewn or glued into the splint at the location of the palm, metacarpal crease, and joints of the fingers to produce the natural position of approximately 15 degrees of flexion.

Figure II. Showing the dorsal or front side of the static night splint.

DESCRIPTION

The brace consists of a fan shaped piece of Celastic moulded to fit the palm of the hand. A piece of felt or blanket material is stretched across the moulded impression and sewn around the flange A (Figure I). Horsehide is then cemented to the felt or blanket material. These two pieces of material form a sling over the impression. The pressure of the fingers and wrist are therefore distributed over the greatest possible area. The hand is held to the brace by one-inch webbing material strapped between the thumb and fingers and across the wrist and forearm.

CONSTRUCTION

It is first necessary to make several different sized hand casts. We have chosen four different sizes: a large man's hand, a medium man's hand,

1. Medical director of the California Rehabilitation Center, Santa Monica, California.
2. Formerly upper extremity prosthetist, California Rehabilitation Center. Presently research engineer, Artificial Limbs Project, University of California at Los Angeles, Calif.
3. Director of occupational therapy department, California Rehabilitation Center, Santa Monica, California.
4. The other articles appeared in the previous four issues of the American Journal of Occupational Therapy.

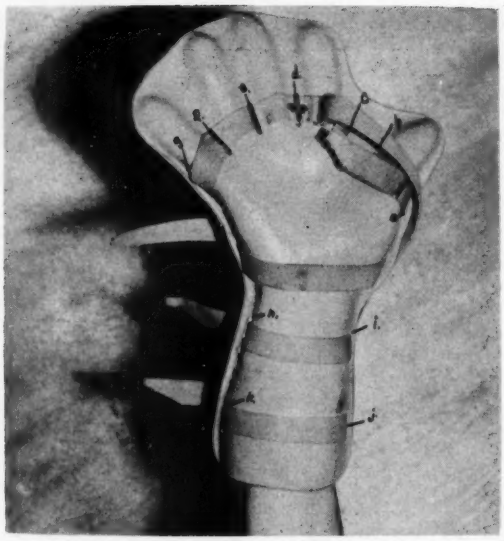

Figure III. Showing the volar or back side of the static night splint.

a medium woman's hand, and a small woman's hand. Since the effectiveness of the splint is not dependent on a close fit, these four sizes serve as moulds for all adult hands. The first step in forming these hand casts is to make a box ten inches wide by eighteen inches long and four inches deep. This box is filled half full with plaster at a consistency of heavy cream. The hand and forearm are pressed half way into the plaster. When the plaster has set just firm, the hand is taken out and the edges of the impression are trimmed and smoothed. This forms a negative cast of the hand. The next step is to make a positive cast from the negative. This is done by applying a separating compound to the surface of the negative cast and completely filling the box of plaster. When the plaster has dried, the box is pulled apart and the positive and negative casts are separated very carefully.

This may seem a long procedure to make a splint, but it should be remembered that this cast may be used over and over again. The best procedure is to first cast the four different sized hands. With care, the casts should last for years and there is usually no need for any more casting.

The simplest method of choosing the right cast for each patient is to place the affected hand in one of the negative casts. If the hand just fits, or is slightly smaller, the cast will be satisfactory in size. The corresponding size of the positive cast is then used to make the splint.

The first step in constructing the splint itself is to brush Celastic parting agent over the surface of the positive cast. The two sheets of Celastic, roughly ten inches by sixteen inches cloth, are saturated in Celastic solvent and formed by hand over the cast, laminating one on top of the other. While still wet the Celastic is trimmed back about one inch from the hand impression.

When the Celastic shell is dry the flange A (as shown in Figure I) is cut on a bandsaw or jigsaw to one-half inch from the hand impression B (as shown in Figure I). A one-inch Rampart bag punch is used to punch holes in the Celastic as indicated in Figure I. A piece of one-quarter inch felt or blanket material, slightly larger than the brace, is cut and coated with rubber cement. Rubber cement is also applied to the flat surfaces (mainly into the flange) of the Celastic shell. Then the blanket material is streched tightly across the face of the Celastic shell, and sewed completely around the brace at

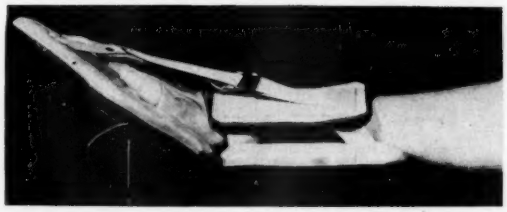

Figure IV. Illustrating the static night splint with a hinged wrist joint. Note the strap holding the hand in wrist extension.

the flange A. The sewing can be accomplished very nicely on a patching machine or on any heavy sewing machine which will accommodate leather.

The blanket material is now trimmed flush to the edge of the flange. A piece of horsehide is cut slightly larger than the Celastic. The inside surface of the horsehide, the blanket material, and the edges of the Celastic are all coated with a good bonding cement (like Barge). The horsehide is now applied to the blanket material side, rolled over the edges and trimmed flush to the back edge of the flange A. The back side or Celastic side is now coated with two coats of Celastic undercoat and one coat of flesh colored lacquer.

The straps to hold the hand in place are made from one-inch grey webbing and safety guard buckles. The strap for the thumb is made about eight inches long and is entered through hole "a" from the back side and returns through hole "b" as shown in Figure II. Two straps, twelve inches long, are threaded through holes "H" and "K" from the front and return by holes "I" and "J", buckling on the front and holding the arm in place. The finger strap is made

(*Continued on page 276*)

AN INTENSIVE ACTIVITIES PROGRAM FOR CHRONIC NEUROPSYCHIATRIC PATIENTS[1]

FRANKLYN BRUCE SPRINGFIELD, M.S.[2]
LOUISE H. TULLIS, O.T.R.[3]

For many years workers in mental hospitals have recognized the crucial role that social and psychological stimulation plays in the treatment of the neuropsychiatric patient. Almost twenty years ago, Abraham Myerson[2] noted that such patients are already ". . . solitary, with lowered initiative (finding) social relationships and contacts either linked up with delusion, or painful in some way or other." He adds, "such a patient is put in an institution. Immediately, whatever remaining initiative he had is taken from him. His social contacts become even more diminished."

In the years since this was written, we have become increasingly aware of this difficulty, and various programs and activities have been instituted to remedy it. Nevertheless, because of insufficient funds and other administrative difficulties the "back ward" patient tends to go unnoticed, as we try to cope with other problems.

The current paper deals with a portion of a project designed to activate and improve the personal and institutional adjustment of a group of chronic, female neuropsychiatric patients. An essential feature of this project was the utilization of volunteer workers, in the hope that staff time devoted to it might be minimal.

ORGANIZATION OF THE PROGRAM

The patient group selected consisted of eight females, with disorders including epilepsy, schizophrenia, and chronic brain syndrome. The average time of their continuous hospitalization was 31 years. All of the subjects shared one characteristic—apathy. They were selected from a larger group of apathetic patients, using statistical procedure to insure a random sample. All resided in the same cottage, located within a state mental hospital. Except for the program described below, the living conditions and treatment of the experimental group were identical to those of the remaining 33 patients in the cottage.

To insure efficiency, flexibility, and minimal demand upon the time of already busy staff members, the organization of the program was kept as simple as possible. A committee was formed, consisting of a physician, a psychologist, and an occupational therapist. The physician was available for consultation, initially reviewed the patients, and expedited those administrative matters with medical implications. The psychologist planned research methodology, conducted group therapy with the patients twice a week, and prepared pertinent case background material for the committee. The occupational therapist, who acted as general program chairman, coordinated the volunteers' activities, being available as a resource for the activity groups, and maintaining close contact with the volunteers and their supervisors. With the psychologist, she made frequent visits to the cottage in which the program was being carried out.

All workers, both staff and volunteer, who dealt with the patients made records of their contacts, aimed at a continual evaluation of patient progress. The occupational therapist synthesized the reports of the volunteers, and with the psychologist and the physician a general picture of the progress of each patient was obtained. This was discussed frequently, informally, and more methodically at a regular monthly meeting of all concerned with the project.

As set up, five afternoons a week were devoted to the project. Two of these were given to group psychotherapy conducted by the psychologist. The remaining three were occupied with activities led by volunteers. These included:

1. Recreation and social
   - Games—active and quiet
   - Walks, gardening, etc.
   - Occasional parties and picnics
2. Music and books
   - Group singing
   - Listening to records
   - Reading periodicals, books, discussion
3. Crafts
   - Knitting
   - Crocheting
   - Simple weaving

The volunteers, whose services were central to this project, and who invested by far the greatest number of hours with patients, were twelve Red Cross Gray Ladies, most of whom had had previous experience in mental hospitals, and were chosen by their supervisor for suitability in this

1. This program was carried out at the New Jersey Neuro-Psychiatric Institute, under the general supervision of Dr. A. N. Browne-Mayers, clinical director. The authors wish to extend their thanks to the many people who helped, and especially to Dr. M. M. Pauleen, then director of psychology at the Institute.

2. Now clinical psychologist at the New Jersey State Prison, Trenton.

3. Director of occupational therapy at the New Jersey Neuro-Psychiatric Institute.

type of program. The division of the twelve into sub-groups provided leadership for all three activity groups. Since only two leaders were required on any afternoon, reserves were readily available to fill in as the need arose.

RESULTS

After approximately four months of operation, five of the eight patients were considered to have improved markedly, two somewhat, and one little. We defined improvement operationally as any change indicating a more favorable adjustment to the environment, to other people, and/or to oneself. In practice this would mean increased participation in activities, in communication, growing freedom in making decisions, expressing opinions, taking initiative, being alert, and willing to work. Evaluation of improvement was based on progress reports, which all workers submitted regularly.

In general, improvement tended to be more noticeable within the activity group than during those times when the project was not in session. This may be another illustration of the crucial importance of the personal relationship between the worker and the patient. We recognize that the goal of any treatment program is improvement in many areas, not only in a few. However, considering the fact that our average patient had been hospitalized some 31 years, and that the program had been in operation four months, we felt justified in the belief that the therapeutic effects of the project would become more generalized with its continuation.

Improvement was manifested in many ways. A patient who fearfully left the room when a volunteer greeted her eventually came regularly to activities. This coincided with a reduction of hostile projections in group therapy. Another patient, who initially avoided any real contact with anyone, approached a volunteer one day, and asked about the propriety of relating a pregnancy dream to her male psychotherapist. (Interestingly, she referred to him as a "philanthropist" rather than a psychologist).

Other patients began dressing up, applying makeup, and going to the beautician. One woman, whose sense of inferiority was so great that she seldom spoke unless spoken to, began to suggest new activities. Periods of lucidity increased, and bizarre ideation diminished. In group therapy it was possible to alleviate behavior which in the past had caused certain patients to be repeatedly segregated from the general population. The successful handling of hostile feelings avoided many problems which would otherwise have incurred necessary restrictive measures by the staff. Perhaps most important, this group of long institutionalized women achieved, in group psychotherapy, remarkable insights into certain areas of their lives. In one typical instance, a patient said spontaneously, referring to a period of acute excitement, "I felt all mixed up inside . . . I was frightened and didn't know what to do, and I was all alone and nobody could help me, so I began breaking things. That's what you call being disturbed, isn't it?"

For others, it meant strengthening of reality ties, coping with loneliness, handling the hostility and impotence which their daily life entailed. In the most dramatic change, a catatonic patient, hospitalized for twenty years, and totally mute for many of them, who had been treated unsuccessfully in the past with ECT, began to participate in group activities and finally spoke a few words.

DISCUSSION

We were fully aware that if our program was to succeed, the emphasis must be placed on interpersonal relations rather than on any special activity. Because of this, the unwritten but actually most important function of the staff committee was a therapeutic one, not only for the patient, but also for the volunteers. Other workers in this type of program have shared the experience that the professional in this situation "really finds himself treating the group that treats the group."[1] Our most important and frequent problems were, therefore, the emotional ones of the volunteers, who had a minimum of formal training for work with mental patients. Rather than precipitate a threatening situation, staff members, after the original orientation, simply made themselves available for group and individual consultation, and waited for the volunteers to come to them.

The problem of insecurity with patients was, of course, the first to come to our attention. This was evidenced in undue concern over the details of patients' histories, difficulties in meeting schedules, a tendency to favor the most responsive and cooperative patients, and misinterpretations of routine procedures. The last is well illustrated by the volunteer who, after watching a routine fine tooth combing by an attendant, of a patient's hair, was convinced of a general lice epidemic.

In addition to conferences, we soon discovered that giving the situation more structure tended to reduce anxiety. A "standard operating procedure" sheet was issued, with special instructions about what to do or whom to call when something arose which the volunteer could not handle. Actually, they made relatively little use of the machinery to handle unusual occurrences but its availability served to diminish anxiety.

As time went on, interpersonal difficulties

shifted into a new area. The initial fear of the patients, relieved by greater understanding, was replaced by a tendency toward over-identification. Some volunteers were concerned over those patients who were not included in the project group; others found it difficult to refuse any patient's request, and at the same time tended to overlook the more withdrawn patient. Rivalry grew up within the volunteer group over who was doing the best job, as defined by getting a difficult patient to attend activities without insisting. (Attendance at all group sessions was on an invitation basis.) Many incidents such as these have convinced us that the most expedient way to improve interpersonal relationships and quiet anxieties is to provide both formal and informal group and individual conferences with trained and sensitive staff members. We found it important to remember that these are volunteers; the level of interpretation by the staff member should be congruent with the situation at hand. The temptation to deal more fully with problems in the emotional area must be restrained, with relatively superficial support and interpretation given to aid operationally. We found, even limiting ourselves rigidly to this principle, that our volunteers gained much from the program, as indeed did we.

Results of this portion of the activity program may be evaluated in three areas: benefit to the patients, to the institution, and to the workers.

In the first area the results, as reported above, are clear. A group of patients, who had reached a plateau of marginal adjustment to the institution, were sufficiently motivated, in the majority of cases, to positively change their overt behavior. They took more interest in their environment; the quality and quantity of their interpersonal relationships improved. Their cottage mates, without treatment, remain unchanged.

The benefits to the institution, in addition to patient improvement, grew from the economy of the program. The average weekly total of paid staff time devoted to the project was less than seven hours. In the current acute shortage of trained personnel, it seems apparent that any who are available can be used most effectively as training and resource persons, wherever possible, rather than line workers. In this manner the physician, psychologist and occupational therapist may be freed to devote time to the specialized tasks which only they can perform adequately. A valuable by-product of utilizing volunteers was the closer integration of community resources into the total hospital program. The attendant values in public relations resulting from this can be considerable.

And by no means least, as noted above, we believe that our volunteers benefited. A mental hospital, more than most situations, stimulates fresh, more acute insights. Not only in increasing self-awareness, but also in the learning and development of new relationship skills, our volunteers will leave the program richer than they arrived. By their own testimony, it is an invaluable experience.

On the basis of our results so far in the project, future research in this area appears justified. Larger groups, more quantitative methods of evaluating patient change, and more extensive exploration of the role of the volunteer might well yield valuable information.

SUMMARY

This program constitutes a pilot study to determine a method and procedure for promoting resocialization in a group of patients afflicted by mental illness over many years. Eight women were exposed to an intensive program consisting of group psychotherapy, recreation, music, and craft activities. After four months, five had improved considerably, two had improved somewhat, and one had improved little. The use of volunteer workers and a simplified organizational plan reduced the total staff time devoted to the project to an average of seven hours a week.

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NON-MEMBER SUBSCRIPTIONS

A rise in the price of non-member subscriptions to the *American Journal of Occupational Therapy* will be effective as of January 1, 1959. After that date, non-member subscriptions will be $6.00 a year domestic, $6.50 for foreign subscriptions. Single issues will be $1.25.

However until January 1, subscription orders will be received at the present rate regardless of the expiration date. So all contemplating a renewal in the near future should place their orders for the *American Journal of Occupational Therapy* before January 1.

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OCCUPATIONAL THERAPISTS AS SPECIALISTS IN MENTAL HOSPITALS

ROBERT SOMMER, Ph.D.*

There are many authors who have written about occupational therapists or recreational therapists[1] from the standpoint of their part in a hospital treatment program and their contribution to a psychiatric team. However, little attention has been paid to their more fundamental sociological role as specialists or experts in large mental hospitals. This can be exceedingly important as many such hospitals are located in isolated areas and have extreme difficulty in recruiting and holding trained staff. In many cases the occupational therapist will be one of the few people in the hospital filling a position for which he has been formally trained. This comes as no surprise to anyone who has worked in any of these settings. It also is not uncommon outside the mental hospital field. A study of three large industrial concerns by Dalton[1] disclosed that only 50% of those with college training were occupied with duties related to their specialized training.

In this paper we hope to discuss some of the implications of the role of expert for the occupational therapist. The problems that he faces often have striking parallels to those confronting experts in industrial concerns and elsewhere. We hope to show that it will be useful if the occupational therapist is aware of the basic ingredients of his role as a person with expert knowledge in a social system where trained personnel are at a premium.

Many administrators are quite concerned with the two basic problems that confront any organization that is contemplating hiring a specialist: (a) How can the trained specialist be used most effectively? (b) How can the specialist be integrated into the organization with a minimum of disturbance?

They are also concerned with defining the areas of competence for the specialist. How far can the administrator go in depending on the specialist? Thornstein Veblen[2] has written incisively about the expert's "trained incapacity to think," how he is often inexpert in other fields. Merton[3] speaks of the expert's adopting a view of limited responsibility as to function. The expert or engineer is content to do his job and ignore the basic implications or general effects of his work. This limited outlook leads to the expert seeing himself in a subaltern role with fixed spheres of competence. There is a view of oneself as a technical auxiliary. In a mental hospital, this can be reflected in leaving all decisions concerning the patient to the psychiatrist. Stainbrook[4] and others have noted the paradox of the nurses, who are best acquainted with the patient, being the most silent of the participants at the staff conferences. There is a fundamental distinction between decision-making and policy-making. The psychiatrist may be the person who sets the treatment course for the patient but it is the task of the occupational therapist and other hospital personnel to decide how their activites can be used to the patient's best advantage.

Laski[5] mentions how the expert often neglects common sense insights or intuition. He confuses knowledge with wisdom and forgets that the ward aide has his share of wisdom regarding the patient. The specialist often has a strong identification with other specialists and views the arguments of non-experts with suspicion. How often have we seen the comfortable feeling at staff conferences where the psychiatrists, psychologists and social workers sit around the table and discuss the patient while the nurses, who must deal with the patients eight hours a day, sit silently around the periphery?

In understanding the role of the occupational therapist as a specialist within a hospital, one must realize the importance of new fads or vogues in therapy within mental hospitals. These create the need for new types of therapies and have changed the atmosphere considerably from the days when only physicians and "keepers" entered the locked doors of the mental hospitals. One therapy has followed another in quick succession, each exerting its influence on the hospitals. The residue may be in the form of hydrotherapy bath tubs neatly stored in the attic, rhythm sticks in an OT closet, or a complicated silk-screen apparatus that no one knows how to operate since the last OT left.

The therapies in a hospital vary with the interests of the staff members and the spirit of the times. When an administrator reads about the benefits from finger-painting or from soothing music, he may become enthusiastic about introducing them into his hospital. Often he finds that the identical idea was tried fifty years ago but was abandoned when some key figure left the hospital. If he reads the archives of his

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hospital, the administrator may discover that his hospital once possessed a red-room (for depressed patients) and a blue-room (for overactive patients), concerts by the town band, and reading sessions for patients by the local ladies club. These were later to become known by more sophisticated terms than "amusement" or "diversion for the patients" but they have their counterparts in the treatment program of any modern hospital. The institutionalization of these informal activities with the gradual emergence of the role of specialist in the activity has created certain problems that may prove disturbing to both the therapist and to other hospital personnel if they are not recognized and an adjustment made for them.

In making an analysis of the situation we may identify several relevant roles:

a. The administrator who hears about a new method of therapy and is interested in introducing it into his hospital.

b. The nurse or other hospital employee who has been employing some of these techniques but without specific training in their use.

c. The artist, carpenter or other specialist who is competent in the use of his medium but who has no psychiatric training.

d. The specialist who has had formal training in the therapeutic use of a craft or specialty in a psychiatric setting.

e. Other hospital personnel who have always viewed the activity in a recreational context and are not aware of its therapeutic potentialities.

f. Civil service directors and personnel managers who object to continually creating new positions and defending them before legislative committees.

g. Other adjunctive therapists who fear that the new specialist will drain funds and personnel away from their own departments.

Every one of these people has a vital stake in the employment of a new specialist in a hospital. Initially there may be serious doubts as to the practicability of the move. Often there is only one key person who pushes for the introduction of a new specialist. He may be the clinical director, the superintendent or recreation co-ordinator, and he may be resisted by a goodly proportion of the staff. If his judgment prevails, the specialist may be entering a situation fraught with skepticism and hostility in some quarters. He enters as a stereotype. Everyone "knows" what a dance therapist will do until they see him work with patients. The same can be said of occupational therapists and music therapists. Although the prevailing verbalized response to his arrival is that "nobody knows what he is going to do here," this does not accurately describe the situation. There will invariably be a plethora of misconceptions about the functions of the new specialist. These are not necessarily malicious or unkind. Rather, they are based on a transfer of expectations from the outside world into the milieu of the hospital. All the adjunctive therapies (AT) must cope with the attitude that their chief goal is to keep the patient occupied. The various specialties must also cope with more specific problems; the music therapist must break down his stereotype as a music teacher; the occupational therapist has to educate the ward staff that his goal is not to give the patient a trade that he can use on the outside, or some of the staff may resent the use of the suffix "therapy" for the activity. These stereotypes can be positive or negative but the specialist should be aware of their existence. If he adopts the attitude that he is a pioneer (e.g. the first dance therapist in Texas) he may alienate the recreation personnel who have been giving dance lessons for years. If he decides to set up a department similar to the one in which he was trained, he may fail because the hospital is organized differently. Furthermore he may alienate the clinical director or some power figure who has been responsible for his coming. The point to be stressed here is not that the new specialist should attempt to confirm the stereotyped impressions of his role or even correct them verbally, but rather that he should be aware of them and attempt to operate in the hospital accordingly. There is little to be gained by adopting an attitude of "this is what an occupational therapist does" when it is far more effective to use the approach of "this is what I have been trained to do." Few roles are highly structured in large mental hospitals, one reason being that there is usually a severe shortage of trained staff. One worker must be able to perform the activities done by another if the hospital is to function properly.

Furthermore any hospital social system consists of a series of interconnected and interdependent roles. The introduction of a new role must necessarily cause temporary strains in the delicate network of relationships. If the specialist is aware of these problems he may be better able to allay the fears of his co-workers and establish a role in which he feels comfortable.

The problems of the specialist also come to public notice in the medical disciplines outside of mental hospitals where patients complain that the specialist "does the same thing as the general practitioner but charges twice as much," or "one specialist never seems sufficient, he will always call one or two more before he will give an opinion." Some medical journals decry this trend towards specialization because it creates a critical shortage of general practitioners. A small rural community cannot usually support a specialist, while a general practitioner is a dire necessity. All of these attitudes have their paral-

lels in the mental hospital. Ward nurses are unhappy when they see that the occupational therapist receives a higher salary for the work the nurse had done previously.

Another parallel in problems confronting the medical disciplines is that the hospital administration may feel there is no coordination between the AT departments. Each one is so specialized that it has lost track of "the whole person." The untrained recreational worker, like the country doctor, was able to give a variety of treatments to the patient without feeling that his professional standing was in jeopardy. He organized the baseball game in the morning, operated the movie projector or bingo game in the evening, coordinated volunteer workers, and came to the hospital on Sunday to help with church services. Like the country doctor, hours and weekends meant nothing to him; whenever he was needed, he came to the hospital. A clinical director or superintendent may expect this to be true of the occupational therapist. Often, however, specialists expect to work an eight hour shift with perhaps a stint on occasional Saturdays. He considers himself part of the daytime hospital staff rather than "on call" throughout the week. He also needs the accoutrements of professional status that the untrained worker never possessed: an office, a part time secretary, prescriptions filled out by the psychiatrist, subscriptions to his professional journal for the hospital library, and permission to attend the convention of his national society. For a clinical director accustomed to the minimal demands of the nurse who used activities on the wards, these may come as quite a surprise. He had believed that if he hired a full-time occupational therapist, the only difference would be more and better OT for the patients. He had not contemplated installing a music system throughout the hospital for his music therapist or turning needed office space into a music listening room, equipped with a high-fidelity phonograph (whose purchase will be extremely difficult to defend before the state budget committee). Similar to the patient who felt that consulting a specialist was a fine idea until he saw the bill and was told the nature of the operation that was recommended, the clinical director may rue his decision and look longingly back to the days when the activity program was handled by the nursing service. However, once he establishes a new structure, it is inordinately difficult to return to the old organization. If the specialist left the hospital, the nurses might feel inadequate in teaching crafts or music again, having seen how the trained worker handled them. They would also demand the same salary and status as the specialist who had carried out the activities. There is a dictum in industrial relations that you cannot have two people doing the same job for different salaries without serious tension. The concept that differential training should be the criterion of salary conflicts with the democratic ethic that the measure of a man is what he is able to do. The identification of education with social class that was so strong in past decades, has created a distrust on the part of the workers for the use of education as the criterion for salary increases and promotion. Workers on production lines have always resented the job that becomes upgraded because it is filled by a college graduate.

There are several problems that are usually faced by the OT who begins work at a large mental hospital. The way in which he resolves them depends largely on his own personality. However, if he is aware of them, he will be in a better position to deal with them intelligently and perhaps plan for them before they arise. This is by no means an exhaustive list but it includes some of the most dificult problems that arise when he begins working at his first job.

CLINICAL WORK VERSUS ADMINISTRATION

The new specialist often arrives at the hospital fresh from a university course or internship. He has received rather close supervision in his work. He has dealt with people who were convinced of the value of his specialty and were eager to make appropriate use of his services. He was continually made aware of the fact that he was a student and he comported himself accordingly. Suddenly he finds himself in an almost polar situation. The hospital administration may have no clear idea of what he has learned in his training. Often there is no one who actively tries to integrate him into the hospital structure. When he enters the office of the clinical director, he is told, "We are certainly happy to have a person with your training here. What will you need in the way of equipment and facilities?" It becomes obvious to him that in hospital protocol, a new, trained specialist portends a new department. Perhaps he has been vaguely aware of this before he came.

He is also confronted by the choice between working intensively with small groups of patients or attempting to reach large numbers in a short amount of time. The resolution of this will be primarily a matter of temperament for either approach can be useful to the hospital and satisfying to the worker. One therapist can work at a hospital for five years and build up a solid appreciation for his specialty in that time. However at the end of that period, the

therapist may want to see another part of the country. This marks the end of the therapy at the hospital until the next therapist appears on the scene. This is one *modus operandi* and it is fostered by many training programs and internships.

The student is trained for clinical work and this was his motivation for entering the profession. In this case, it serves neither the hospital nor the therapist to transform him into an administrator. This certainly is not peculiar to the adjunctive therapies. Nursing texts frequently lament that nurses are not being trained for administrative work although they are being required to function in this way. The American Psychiatric Association is concerned that so few young psychiatrists are interested in administrative work. Countless examples could be given for service occupations where personnel enter for altruistic reasons and are then confronted with the hard realities of survival in a world of supervisory problems, requisitions and departmental relations. The choice between helping a few individuals and helping the masses is a theme that has dominated a score of novels and plays. An equally poignant although less dramatic novel could be written about the OT who enters the hospital bent on doing clinical work who is channelled into administration.

Although the occupational therapist may feel that administrative considerations are of secondary importance, he eventually will find that he has certain moral responsibilities to the hospital that cannot be filled solely by work with patients. If an OT requisitions special equipment for his activity (a kiln, silk-screen process, etc.), he becomes obligated to train other employees in the use of the equipment. Almost every hospital has a room containing storage drawers filled with materials that no one in the hospital knows how to use. This may discourage the clinical director when a new specialist asks for some additional apparatus. The first question that he asks is whether the specialist is going to remain at the hospital long enough to justify the purchase of the equipment. Then he would like to know what is going to happen to the equipment when the specialist leaves the hospital. If the clinical director does not ask these questions, the business manager undoubtedly will.

The hiring of trained occupational therapists, art therapists, and music therapists, tends to polarize the adjunctive therapy departments into those with specialized training in an art or craft and those without it. Where there are only one or two AT specialties, the situation is not serious. When the number exceeds two or three, the gulf begins to widen. One of the departments finds itself charged with several onerous and time-consuming chores such as editing the hospital paper, driving patients into town, and making the arrangements for an open house. A new specialist in the hospital will ordinarily accept those activities that fall within the aegis of his art medium (e.g. the OT will teach a craft class for staff families, the music therapist will supervise the Saturday night square dance). The activities that are unrelated to any craft or specialty will usually fall on the department with the least craft training. This may prove to be a source of inter-departmental friction as the miscellaneous tasks can require evening and weekend work in addition to being dull and time-consuming. The person who chooses a career in recreation may enjoy baseball and outdoor work but be thoroughly unhappy in editing a hospital newspaper or speaking to groups of visitors. In medicine, the generalists (GP) are complaining about the burden of work that they do in comparison to the specialists. One physician[6] righteously asserts that "if the general practitioners went on strike the whole superstructure of specialized practice would collapse and unfortunate internists would have to take blood pressure and surgeons would have to make night house calls." The same point applies to adjunctive therapists who have not had specific training who feel that they have been burdened with the routine chores while the specialists are "doing only what they want to do."

WARD WORK VERSUS SPECIAL DEPARTMENTAL ROOMS

Wherever possible the specialist should perform some of his activities on the ward and with the participation of the ward nurses. If this is not done the ward nurses may resent being left out of the therapeutic program of the hospital. This fosters a custodial attitude among the ward personnel who see themselves simply "looking after the patients" when the patients are not receiving therapy. They begin to feel that all therapy takes place off the ward while the ward becomes a place for the patient to eat, sit, and sleep. Behaviorally, they begin to look upon the OT hour as a good opportunity for a coffee break in the nurses station. The nurses also lose the opportunity to observe their patients interacting in a new situation. The ward environment is usually quite impoverished and does not allow the nurses any chance to note improvement in a patient beyond a minimum level (toilet training, eating, etc.). If the nurse can see her patient in a new activity, she may observe potentialities and skills that she has never suspected. Often the nurse erroneously credits these gains to the adjunctive therapists when, in fact, it was simply that the limited

environment on the ward allowed no opportunity for these latent interests to emerge.

Observing or participating in the leatherwork group or pottery class will permit the nurse to capitalize on any improvement in the patient's degree of socialization. If she is not present during the activity the nurse may be unaware that any changes have occurred and the patient may slip back to his former level. Possibly a situation analogous to that in insulin therapy will appear, i.e., where there is a brief period of lucidity immediately upon awakening which is the optimal time for communication with a patient. Often a psychiatrist or a nurse will remain by the patient's bedside in the hope of talking to him the moment he emerges from the coma. Perhaps the improvement produced by a dance or craft session can be consolidated only if communication between patient and nurse begins immediately after the activity. If the nurse has been present, then she and the patient can comfortably talk about the activity itself. The nurse has participated in an activity with the patient. They are discussing a shared experience. Anyone who has conducted a group therapy session knows the difficulty involved in finding topics of conversation that are meaningful to both patient and therapist. There are no better topics than experiences shared by all the participants. The same principle applies to the nurse and her relationship with the patient. There is little opportunity for her to do anything with the patient on the ward. She may do things for him but this is vastly different. At an OT session, both patient and nurse can become genuinely interested in the activity. They are doing something together and a close bond may develop that can be capitalized upon later by the nurse.

EDUCATION OF THE WARD STAFF

In addition to training ward personnel so that they may join his department, the therapist must attempt to educate other nurses so that they do not develop negative attitudes toward the activity. Particularly with a new therapy at a hospital, the specialist must undertake a rather extensive public relations campaign to convince the ward nurses of the value of the activity for their patients. If the nurses are highly motivated they usually adopt a pragmatic approach to AT: if their patients seem improved after the session, then it was a worthwhile activity. If the nurses are poorly motivated, then any activity that fills the hour will be acceptable. However many activities will strike the nurses as rather odd and senseless. Although a nurse will sometimes evaluate an OT department by the quality of the goods for sale in the craft shop, it is difficult to do this with other adjunctive therapies. It may be quite disturbing to a nurse to see her patient in an expressive movement session. Some nurses will complain that leatherwork is not sufficiently masculine for their male patients. In hospitals where the nurse is expected to participate in activities with her patients she may look forward to the OT hour with apprehension if she feels that she is not sufficiently skilled in the activity. All of these attitudes can undermine the therapeutic value of an activity at a hospital. The nurse is the most important factor in a patient's ward milieu and when the patient senses that the nurse attaches little importance to an activity, he is not likely to value it highly himself.

THE EDUCATION OF VOLUNTEER WORKERS

It has been shown repeatedly that when volunteer workers are not given sufficient direction and assistance from the hospital staff, their contribution to the treatment program is negligible and often negative. At hospitals where definite programs for volunteers have been established, with a full time co-ordinator of volunteers[7], the hospital has reaped the gains from a vastly enlarged pool of personnel available, especially during the evening hours when staff is usually quite short. However these volunteers must be given some training or orientation to the hospital if they are to be at all useful. We have numerous instances where volunteers have been locked out of wards, unable to locate the ward on which the OT shop was located, or were given no assistance by the nursing staff in getting the patients assembled. Perhaps no one in the hospital is better trained or qualified to train or direct these volunteers than the occupational therapist. If he considers them as "intruders" or "well-intentioned but ineffectual clubwomen" and makes no effort to educate them, then he is losing a valuable means of supplementing his staff. Von Mering and King[7] note that this consultant role to volunteer groups serves to give the AT departments additional status and the feeling that they are professional workers.

SOCIAL SITUATION

Another interesting point is that the trained specialist is often regarded as a transient employee. Isolated state hospitals are accustomed to having professional employees come to the hospital and remain for a period of months. Carpenters, nurses and accountants seem far more stable than psychiatrists, occupational therapists and psychologists. It is not uncommon for the staff to openly express their surprise that the OT came to the hospital. Some hospitals feel as if they are little Ellis Islands for professional

(*Continued on page 276*)

A LEATHER PUNCHING DEVICE ADAPTED TO THE DRILL PRESS

RUTH WINER, O.T.R.*

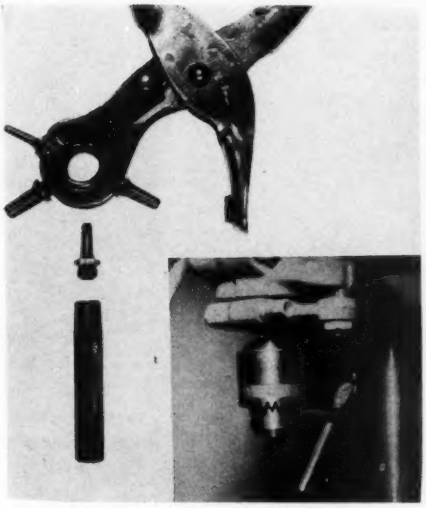


Figure 1. A tube from a leather punch, a two and a quarter inch length of lamp pipe, and the chuck of a power drill.

Leather projects which require that the holes for lacing be punched by hand often must be withheld from certain patients or restricted in the extent to which they can be used by others because (1) a considerable amount of strength in grasp is necessary to operate the hand punch, (2) the use of the hand punch requires a palmar skin which is sufficiently tough to avoid injury, (3) repetitive punch action tires the hand muscles very rapidly and causes pain which considerably retards work on the project or (4) there is an important drain on the therapist's time if she must do this part of the activity in preparing the project for the patient.

The described simple device of adapting a leather punch to a power drill involves no expense and effectively obviates all the disadvantages listed above.

DIRECTIONS

A tube of the desired size is removed from a standard revolving punch and inserted into a two and one-fourth inch length of lamp pipe which is threaded on the inside to hold it. The other end of the pipe is fitted into the drill chuck. (See Figure 1.) This can be accomplished by the occupational therapist in the following manner:

1. Cut a length of lamp pipe two and one-fourth inches. Since the threaded ends of all tubes in a single revolving punch are standard size, only one length of lamp pipe is required. Hollow lamp pipe is used because it has the necessary durability and strength, and because it receives and permits emptying of the punched out pieces of leather.

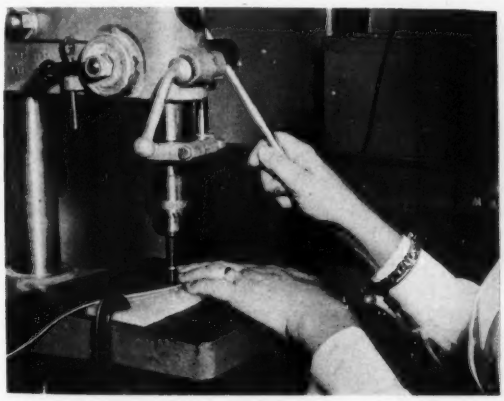


Figure 2. The drill press and adapted tube assembled for operation.

2. Remove a tube from the punch and have a carpenter, machinist or plumber thread the pipe so that the tube may be screwed into it.

3. Screw the tube into place in the pipe. It must be tightened as firmly as possible since, if the tube loosens, it will move out of line and not cut clean.

4. Insert the pipe into the chuck jaws of the drill press as you would an ordinary bit. (See Figure 2.)

5. Cut a piece of one-fourth inch Plexiglas approximately two and one-half inches by five inches. This is placed over the center hole of the drill table. The leather to be punched is placed on this. Plexiglas is well adapted to such use. Wood is too soft, and some metals are so hard that they dull the tube. It may be desirable to clamp the Plexiglas to the table.

6. Adjust the height of the table and set the stop nuts so that the tube meets the Plexiglas.

7. Adjust the feed handle as desired in order to obtain either elbow and shoulder flexion or elbow and shoulder extension in performing the activity.

The device is now ready for operation. Try a practice piece of leather and reset the stop nuts if the tube does not completely punch the holes. The activity is performed with the power turned on but it may be used with the power turned off for increased resistance, or as a precautionary measure. One must remember to empty the tube at suitable intervals.

This device has been used in the occupational therapy department of the Beth Israel Hospital for the past year and has been found to be consistently practicable and useful. It has permitted us to include a much greater variety of compli-

(*Continued on page 256*)

*Occupational therapy department, Beth Israel Hospital, Boston, Mass.

UTILIZING SCIENCE EXPERIENCES IN A PEDIATRIC PROGRAM

ELAINE TRAVIS GORDON, O.T.R.[1]

A pediatric occupational therapy program should challenge the developmental needs and interests of the children concerned. The pediatric occupational therapist in an institutional setting needs to provide the children with opportunities for new experiences in this physically limited environment. Science, as an occupational therapy medium, is an unexplored area of learning which absorbs the child's interest and stimulates his awareness of things around him. Science activities can serve to meet the specific needs of treatment through functional exercise, prevocational evaluation, or developmental or psychological guidance.

Curiosity and a trip to the science section in the children's department of the public library is the first step for the therapist who initiates this activity medium.

Here are some ideas and questions which youngsters enjoy exploring.

1. *What materials does a magnet attract?* The children are given magnets and go hunting within their reach to try various materials and develop some conclusion. To make this science experience meaningful for development, the therapist must ask the child to describe the nature of the materials which he tries the magnet on, and to name the common properties among the things attracted and those not attracted.

2. *Tin can telephones* illustrate that sound vibrations travel along a string. Heavy cord and tin cans with holes are the supplies needed. This medium is particularly good to meet the need of a "private wire" for the preadolescent or to encourage speech development when necessary.

3. *Soap bubbles* blown through the end of a straw provide an opportunity to view the colors of light rays broken up by the bubble.

4. *For electricity experiments,* a 2½-volt dry cell (this is too weak to be dangerous), an electric wire, a tiny light bulb and socket, and a nail provide enough material for several experiments. Make a circuit so the light bulb will stay on, make a switch by attaching the end of the electric wire to a nail, and make an electromagnet by winding the wire in the circuit around the nail. Hint: The electricity won't flow unless the wire connects the dry cell to the bulb or nail and the circle of wire is complete.

5. *Weather charts* made with a movable point in the center and a selection of pictures of how the weather looks on a sunny day, a rainy day, and a cloudy day helps maintain the young patient's outdoor interests.

6. Another activity about which a young scientist can keep records is *growing seeds.* Plant a lima bean seed between a moist paper towel and the outside of a glass. The child keeps a visual record of his experiment by hypothesizing how the seed will look as it grows and then drawing in an adjacent column the actual changes which occur.

7. Some hospitals have *animal rooms* and allow a healthy rabbit to be taken to the children. The children can speculate on the age of the rabbit, his food and living habits. They can compare these habits with other animals.

8. Children enjoy *opening cans of juice* and mixing two flavors of fruit juice, serving it to others, and having the others guess what flavors were mixed.

9. *Science fiction* writing is an interest particularly worth stimulating for long term patients. The therapist shows the children five things. As each article is shown to the children, they are asked, "What shall we pretend this is?" Then, "Let's make up a story about these things. What happened?" The therapist writes down all that is said by the children. She contributes only "What happened then?" When the story is completed, the therapist types copies for the children. The young authors can make illustrations for their book and then sew the pages together. Since this is a relatively unstructured activity, the creative group writing lends itself to making specific observations on individual children and their comments.

1. Occupational therapist, department of occupational therapy, Hospital for Joint Diseases, New York.

Punching Device . . .

(*Continued from page* 255)

cated leather projects than was previously possible. The time consumed in punching holes is minimal. The activity offers specific exercise for elbow and shoulder flexion and extension. It permits a one-handed patient to punch leather with ease and accuracy.

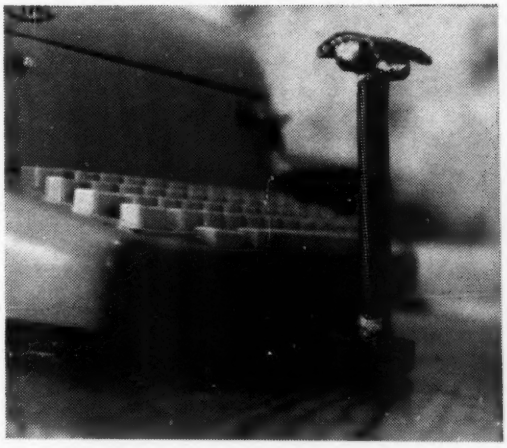
SUMMARY

A leather punching device is described for adaptation to the power drill. The ordinary tubes from a standard revolving punch are fitted to the press by means of a threaded length of lamp pipe.

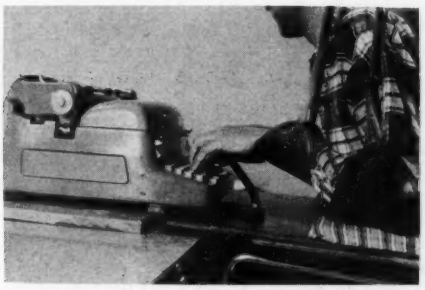
Picture Page

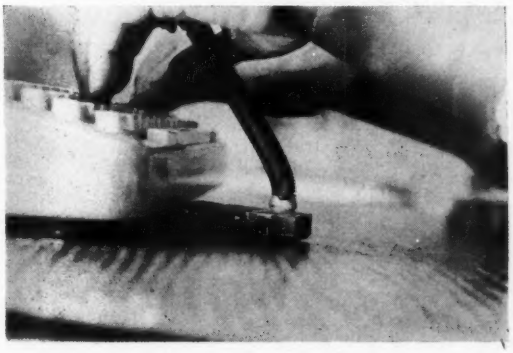
Typing Devices

Apparatus for supporting third and fourth fingers which lack extension power.



Excessive weight on the adaptation is prevented by the patient's utilization of arm slings. The apparatus places no tension upon the patient's fingers.





The patient rests his fingers on the finger caps between the metacarpophalangeal and proximal interphalangeal joints. He is able to flex to strike the keys, and apparatus allows fingers to come back into extension when released.

The finger caps are shaped with the curvature of the patient's left ring and middle fingers, which along with the application of felt to the caps, provides maximum comfort for the fingers.

*Pictures submitted by Phillip D. Shannon, a student at San Jose State College, San Jose, California.

NATIONALLY SPEAKING

From the Recruitment Committee

During the months of May and June two of the regional workshops on recruitment were held in Richmond and Minneapolis respectively. These were the first regional meetings held by a health agency for the express purpose of recruitment and were made possible through a grant from the National Foundation for Infantile Paralysis (now known as the National Foundation) which enabled us to pay for the transportation of participating recruitment chairmen. All school directors within the region were invited to attend or to send a representative.

These meetings (there are to be two more—in Dallas and San Francisco) stemmed from the recruitment committee meeting in Cleveland where it was suggested that sub-chairmen of the recruitment committee be appointed to facilitate better recruitment coverage on a national level. Four regions were formed, the Eeastern, Northern, Southern and Western. Chairmen were elected at the regional workshops, already held. Margery Peple, O.T.R., is the chairman of the Eastern region and Dorothy Hruby, O.T.R., will represent the Northern region. Due to the stress of time it was not possible to hold all four meetings before October but these are being scheduled for the near future when the remaining two chairmen will be elected. A solid program for each region will then be formulated under the direction of the regional chairmen.

The programs in both workshops though not identical were similar. After a social evening the workshop convened to discuss questions drawn from write-in cards sent to the national office by participants. Among the questions considered were:

1. The organization of a recruitment committee with respect to abilities needed, non-OT membership (or consultants) and geographical coverage.
2. Specific projects that could be undertaken.
3. Means of financing a recruitment program.

A role-playing demonstration with an O.T.R. interviewing a potential recruit sparked a lively discussion in both workshops and pointed up the need for a more down to earth approach on the part of the professional person when relating to the lay individual.

Two panels were held in the afternoon with speakers from the field of communication—radio, TV and the newspapers—and from local representative organizations. Here again a wealth of information relative to how these media could be used was made available to recruitment chairmen.

An official dinner was held in the evening with a key speaker and we were pleased to include in our audience representatives from the National Foundation and the Health Careers Project of the National Health Council, both of whom contributed richly to our program.

On Sunday morning a clinic was held during which some of the immediate problems and questions pertinent to the regional area were considered. All participants were charged with the task of evaluating the workshop and the seriousness with which this was considered was manifested in the excellent response sent to the AOTA office. This evaluation will serve as a guide for future action and will be included in a summary of the minutes of the meetings which are now being prepared and will be sent to all state chairmen. It was felt that the entire weekend not only was of great help to new chairmen but was valuable to those already functioning.

We wish especially to thank the Virginia and Minnesota Associations for their assistance in contributing to the success of the meetings. With very little time they expedited many situations that could not have been met from the national office.

We might do well to pause and reflect on some of the facts that were brought to our attention as a result of these meetings. Enrollment in our schools has fallen off perceptibly; positions are being filled throughout the country by non-qualified people and those long vacant are being withdrawn. Our investment in our profession is too great to allow us to permit its deterioration for lack of personnel. Your recruitment committee cannot carry the burden alone. A national recruitment program depends on your cooperation, too. Working and non-working O.T.R.'s are both deeply involved in the future of our profession, the former with the immediacy of his needs and the latter because he may wish some day to return to his field.

The competition we face is a common one in all the health fields. This was cogently brought to our attention by the representatives from the National Foundation and NHC's Health Careers Project who played active roles in the Eastern Region meeting. The reasons for shortages in the service fields are well known and we know too that the competition with industry is formidable. In light of this it is wise to examine the other side of the coin. Alone, our efforts are limited. Our cry is a small one in the wilderness. It becomes emergent therefore that we join forces with other services who are also facing similar

problems. Let us recruit for a health career. Individual effort is important but unified effort is more effective. If our student is not interested in OT, he or she might be interested in physical therapy or nursing and if not in nursing or physical therapy perhaps OT. Recruit we must. This is no longer a matter in which we can choose to be interested—it is a demand made upon us for our survival.

— Frances L. Shuff, O.T.R.

Curriculum Study Personnel

Before this issue of the Journal reaches you, the project staff for our national association's curriculum study will be on the job in New York and, soon after that, visiting hundreds of you in both clinics and schools throughout the country.

The personnel line-up for this major professional study is outlined below. Although all of them have been active in both state and national activities for a number of years, these brief facts point up their special qualifications for the curriculum project.

Miss Marguerite Abbott, project director, holds a BS from Tufts University and MA from Columbia. Her undergraduate work in the field of education was augmented by graduate work in educational administration which included a major segment devoted to designing and evaluating various types of curricula in occupational therapy. Currently on leave of absence as assistant professor in occupational therapy at Columbia University, Miss Abbott will be in the British Isles from September, 1958, through March of 1959, first as visiting professor in occupational therapy at the Astley-Ainslie School of Occupational Therapy in Edinburgh, Scotland, and subsequently doing graduate work in international comparative education at the University of London.

The greater part of Marguerite Abbott's professional experience has been in education and has included academic appointments at the Boston School of Occupational Therapy as well as Columbia University. Her early clinical work in cerebral palsy at the Buffalo Children's Hospital was followed by broad experience in other fields in positions at the Queen's Hospital in Honolulu, Brattleboro (Vermont) Retreat and Boston's Liberty Mutual Rehabilitation Center.

Miss Abbott will return from her work abroad on April 1, 1959, at which time she will assume full-time direction of the curriculum study.

Miss Mary D. Booth, who will conduct the academic survey phase of the study, was awarded her bachelor's degree from Wellesley College and her master's degree from San Jose State College. Extensive clinical experience was primarily in the field of orthopedics and pediatrics and included positions with the Wisconsin Children's Orthopedic Hospital in Madison and the New Jersey Orthopedic Hospital in Orange. For the past several years, she has directed the occupational therapy course at San Jose State College, a position which has included both academic teaching and student affiliation supervision.

Miss Abbott

Miss Booth

Miss Booth's graduate degree in psychology included work in statistics, experimental psychology and a thesis studying the relationship between certain personality factors and success in clinical training of occupational therapy students.

Miss Welles

Miss Carlotta Welles, who will accomplish the job analysis phase of the curriculum study, is a graduate of Scripps College and received her master's degree from the University of Southern California. This general and professional education has since been supplemented by a number of special courses in administration, supervision, rehabilitation and skills subjects. Her clinical experience includes occupational therapy appointments as follows: Hartford Hospital, Hartford Chapter of the National Foundation for Infantile Paralysis, Birmingham Army Hospital, U.S. Army Western Area OT Consultant, May T. Morrison Rehabilitation Center of San Francisco and the Los Angeles County General Hospital.

Most recently, Miss Welles has organized and directed several graduate courses at the University of Pennsylvania and for state occupational therapy associations. She is currently at work on a text covering the principles of administration for rehabilitation personnel.

Miss Wilma L. West, initiating coordinator, will direct the project from October, 1958, through March, 1959. Her AB is from Mount Holyoke College and MA from the University

of Southern California. Clinical experience at Boston's Robert Breck Brigham Hospital and the Army's Walter Reed Hospital in Washington were followed by positions with the national association, first as educational field secretary and later as executive director. Subsequently, she organized and directed the occupational therapy course at the Army Medical Service School, Fort Sam Houston, Texas.

More recently, Miss West has been associated with special study projects sponsored by the Office of Vocational Rehabilitation and the National Institute of Mental Health. She currently holds appointments as consultant in occupational therapy to the Army Surgeon General and counselor, National Society for Crippled Children and Adults.

In addition to the O.T.R.'s, the curriculum study will have the consulting services of a job analyst and curriculum specialist skilled in directing the development of special materials and techniques to be used in the two major phases of the study. Overall project direction will be in the hands of the Association's education office and an advisory committee composed of representatives of both schools and clinical centers.

Since October first, the project staff has been at work on preliminary phases in Room 1113 at 250 West 57th Street in New York, just three floors below our national office headquarters, where existing space was inadequate to the absorption of additional staff personnel. They will welcome communication with all therapists, by letter before the field surveys begin and, early in 1959, in person with O.T.R.'s in numerous schools and clinics scheduled to be visited.

Future issues of AJOT will carry further information on this important professional study. The December issue will detail plans, methods and anticipated results of the study. Watch for it.

REPORT FROM COPENHAGEN*

Second International Conference
WORLD FEDERATION OF
OCCUPATIONAL THERAPISTS
August 11-16, 1958

Opening Session

"As convener of the Danish Congress Committee I have the great honor and privilege of extending a most hearty and warm welcome to you all, and I don't think that I can do it in more appropriate words than by quoting the little song with which the Norwegian explorer Thor Heyerdahl and his men were greeted by the inhabitants when they reached the small island in Polynesia after their fabulous voyage on the Kon-Ti-Ki raft. The words of the song sounded like this: 'Welcome you are who have come across the sea to us, welcome. May you stay long with us and share memories with us, so that we can always be together, also after you have returned to your faraway homes. Welcome.'"

With these words, Miss Ingrid Pahlsson, First Vice-President of WFOT and convener for the Danish congress committee opened the congress and introduced us to a week full of never-to-be-forgotten experiences. This combined report from some of us who were fortunate enough to participate in this week of work, fun and learning is our attempt to share parts of this exciting experience with you. It has been our privilege to join in a common bond with the seven hundred and fifty representatives from thirty-two countries; and through work and comradeship to better understand each other's professional methods and problems. Come join us for a few minutes and sample the things that have happened to occupational therapists this week in Copenhagen, Denmark.

President's Address of Welcome

Clare Spackman, O.T.R., *President*

The World Federation of Occupational Therapists has grown rapidly—at the second congress held in Copenhagen there were more than 700 delegates, representing 31 countries. In 1954 there were 420 representing 20. Ten new schools have started in the last two years—and there are a number of other potential courses.

The World Federation was glad to welcome as new members the Occupational Therapy Associations of Norway and Western Germany.

There has been much accomplished in the four years by our Federation in giving advice and guidance in education, treatment procedures, and assisting individual therapists in planning programs of study in different countries.

Two documents have been published: "The Establishment of a Program of Education for Occupational Therapists" and "The Organization of an Occupational Therapy Department."

*Report written and compiled by: Delegates Marjorie Fish, Helen Willard, Marie Louise Franciscus; U. S. Representatives Marguerite Abbott, Helen Mathias, Margery Peple.

There are many plans for the future but in the last analysis the future of the World Federation of Occupational Therapists depends on the support, moral and financial, of occupational therapists all over the world.

The theme of this conference is "Occupational Therapy as a Link in Rehabilitation." As a frame of reference for us all the following statement regarding occupational therapy is presented.

Occupational therapy is a rehabilitative procedure which is prescribed by the patient's physician. It is specific medical treatment and for this reason the physician's prescription for occupational therapy is part of the medical record. It is the occupational therapist's responsibility to place it on the medical record with a reply and to write periodically on the patient's progress in occupational therapy.

To carry out the physician's prescription the occupational therapist must be especially educated to act as the physician's assistant and to report objectively to him the results of the treatment.

The activities used as treatment, be they crafts, creative art, adult education, adapted games or supervised work experience, will vary depending on the physician's prescription and the patient's needs. The basic principles in using activities remain the same.

Because we in occupational therapy frequently use crafts or other activities which result in a finished product or article, there is always a danger that the emphasis will be placed on the completed article. The completed article is the by-product of occupational therapy, just as the delightful Christmas decorations made of straw are a by-product. The wheat or oats were not grown to provide straw to make Christmas presents but to feed man or beast. Occupational therapy is prescribed by the patient's physician to obtain certain objectives and to contribute to his recovery and return to the greatest possible personal, social and economic independence.

Rehabilitation is a concept, not a technique. It is being taught to all medical personnel. It is not the function alone of the physical and occupational therapist, but rather of the medical team in action. The first and most important member of this team is the patient. To help him achieve total rehabilitation are the doctors, nurses, therapists, social workers, psychologists, vocational counselors, et al. Each patient's needs vary, few need the service of all the team members, but each in his turn plays his part.

It is only through working together with the other members of the team that we in occupational therapy can achieve our goal: To be of greater service in the rehabilitation of the patients of today and of the future.

Report from the Delegates of the Ten Member Nations

The *American Association* reported for 6,000 therapists, 2,240 students and 150 members of WFOT. Members were invited to attend the 41st annual conference of AOTA, in New York this October. Announcement was made that the third conference of WFOT has been scheduled to be held in Philadelphia in 1962 and all Congress members were urged and invited to attend.

The delegate then emphasized four areas of professional growth as evidenced in activity in the States during the past four years: (1) self-evaluation, (2) an increasing body of literature, (3) opportunities for graduate study, and (4) research activity.

Australia reported for 220 therapists and three schools; the beginning of state registration in Western Australia, post graduate lecture opportunities, and the Pan-Pacific conference on rehabilitation sponsored by the International Society for the Welfare of Cripples, to which Miss Fish has been invited. The Association has received official recognition from the federal body of the British Medical Association.

Canada had 275 therapists in 1954 and has 326 today, of which one third are Canadian trained before the combined course, one third are combined OT-PT's and one third are from other countries. An advanced standing course is in the planning stage to assist in relieving a severe shortage of therapists. An OT assistant course has been started. There are at present three schools with an enrollment last year of 70 students. Low salaries are thought to contribute to the shortage of personnel.

Denmark also reported a shortage of personnel and also indicated low salaries as a contributing factor. Men are trained.

Great Britain has 1,689 therapists, and 8 schools in England and Scotland as represented by the Joint Council. Salaries are established by the National Health Service. Men are trained.

India has 70 occupational therapists, with forty-five percent being men. Students have been trained for Malaya, Indonesia. A second school has been opened at Napur.

Israel has 7? practicing graduates from its own school and 7 therapists from abroad. There are 27 operating departments that have been built in the past ten years since the beginning of the State.

New Zealand held its tenth annual council meeting and reported on the establishment of a sheltered workshop program.

South Africa has 46 therapists in the three areas of Capetown, Pretoria and Johannesburg, 2 schools in the latter areas and 24 departments in Capetown. It has been necessary to close several departments for lack of personnel.

Sweden has 180 therapists, of whom 40 are WFOT members. There is one school with an annual enrollment of 20 to 25 students.

Several additional countries were represented at the congress and many of them indicated the hope that they could make application for WFOT membership prior to the next Congress in 1962; Austria, Belgium, Brazil, Finland, France, Germany, Ghana, Hungary, Iceland, Italy, Jamaica, The Netherlands, Nigeria, Norway, Portugal, Singapore, Spain, Switzerland, Yugoslavia.

Highlights from the Council

The Council of the World Federation of Occupational Therapists met for three days prior to the second world congress in Copenhagen, August, 1958, and held two interim meetings through the week. Ten member countries were represented (Australia, Canada, Denmark, Great Britain, India, Israel, New Zealand, South Africa, United States) and two countries sent observers (Norway and Germany). These latter two countries completed their applications and were admitted to full membership status by the end of the week.

Mrs. Glyn Owens who has served as secretary-treasurer of WFOT since its organization in 1952 resigned. Her position was filled by Mrs. Thelma Cardwell of Canada. Mrs. Owens consented to accept the position of assistant secretary-treasurer.

The following were elected to office:

First Vice-president ....Dulcie Goode, Australia
Second Vice-president ....Grizel MacCaul, Great Britain

Chairmen of Committees:

Legislation .....Grizel MacCaul
Education .....Helen S. Willard
Congress .....Marie Louise Franciscus
International Relations .....Margaret Fulton
Membership .....Thelma Cardwell

Reports were received of the pre-congress study tour held in London; the meetings held in London and New York since 1956 at which WFOT has been represented; congress arrangements; the secretary-treasurer's report and many other matters.

Two publications have been prepared, one dealing with the organization of a program of education for occupational therapists, the other with the organization of an occupational therapy department. These will be available through local associations of occupational therapy. They are being translated into French.

The location of future meetings was tentatively set as follows:

1960: Council Meeting, Sydney, Australia
1962: Third Congress, Philadelphia, U.S.A.
1964: Council Meeting, invitations were received from Israel and Sweden.

Highlights from the Meetings

General Session. The theme: "How to Establish the Ideal Teamwork in Hospitals and Institutions." Complete rehabilitation of the handicapped individual is achieved only through cooperation of all those concerned with the treatment. The physician should be the leader of the team . . . The effectiveness of the team is demonstrated when the institution meets the needs of the patients and the staff . . . Each member has a role to play and has rights and duties assigned, the older professions having a more definite role and thereby emotional security . . . Weakness is caused by loose role definitions with unsureness of function and rights within the particular role or overlapping of roles . . . When status is not threatened, the team member contributes to the professional growth of others . . . Lack of communication is a symptom rather than a cause of team breakdown. Everyone is responsible for the results in each patient's case; the lack of success is everyone's responsibility.

Each team member must be familiar with his own field and understand the broad outlines of that of others. Each must know when to take over and when to hand over . . . Meetings should be held regularly (at least once a week) to discuss cases and problems. Individual contact with other team members is important and good interpersonal relationships should exist . . . Membership of the team varies with the type of institution or treatment center and the stage of progress the patient has reached. The usual team members are the physician, the nurse, the psychologist, the social worker, the physical therapist and the occupational therapist with other disciplines being represented as needed . . . And a most important point not to be overlooked or neglected is that the family and the patient are also members of the team.

Psychiatry. The panel of speakers was chaired by Professor, dr. med. Villars Lunn, Denmark, and included Chief Physician dr. med. Georg K. Sturup, Denmark; Mrs. A. M. Johnston, O.T. Reg., Canada (reading a collaborated paper by Azima, Azima, Johnston and Wittkower); Janette Meader, M.S.A.O.T., England;

and Chief Physician, dr. med. Gudmund Magnussen, Denmark.

The panel members considered the needs of psychotic and neurotic patients as well as psychopathic personalities and the essential premise of meeting the needs of the individual rather than treating symptoms . . . A theoretical formulation of dynamic occupational therapy was presented and a program of short term treatment for patients in a small voluntary active treatment center was skillfully outlined . . . A review of chemotherapy principles encompassed a brief description of three general areas of occupational therapy emphasis for these patients . . . All speakers emphasized the need for good patient-therapist and team relationships, reduced anxiety in the environment and improved communications between members of the treatment team.

Rehabilitation of Children. This session was chaired by Professor, dr. med. Preben Plum from RIGSHOSPITALET, Copenhagen, Denmark. The medical and OT aspects of amputations, poliomyelitis, cerebral palsy, mentally subnormal children and the deaf patient were presented by a physician and OT in each area. Occupational therapists taking part in this panel were: Jeannine F. Dennis, O.T.R., California; Muriel F. Driver, O.T.R., Georgia; Marguerite Abbott, O.T.R., New York; Agnes Dick Ness, O.T.R., New York.

Geriatrics. In caring for geriatric patients, efforts are made to constructively fill out the time for these people, keep them in contact with the community and increase their self-confidence and feeling of usefulness. General weakness becomes a principal complaint in many people after the age of 70 . . . In a rehabilitation program, it is desirable for the patient to experience satisfaction and pride in being able to accomplish self-care activities again . . . Rehabilitation of these patients should be in a positive and optimistic atmosphere with stress upon encouragement . . . Training patients to work according to their newly discovered capacities and to be interested in themselves and their neighbors will contribute to restoring their physical and emotional integration. The therapist through observation of behavior and performance can contribute much to the clinical understanding of the patient.

Exhibits. The exhibitions were divided into three parts: (1) the scientific exhibition representing the newest trends in OT from all parts of the world, (2) the commercial exhibits coordinating the patient's treatment program with the demands of everyday living and (3) the Danish industrial arts exhibit representing the tradition of handicrafts in Denmark.

Entertainment

The gracious hospitality of the Danes was highlighted in the numerous social functions. Entertainment was arranged for delightful socializing in settings which typified the rich culture of Copenhagen and the stalwart country of which it is such an integral part. The Association of Danish Occupational Therapists welcomed congress members on the evening before the congress opened at a reception in the outdoor courtyard of the national museum located in the heart of the city. This affair was graced by Her Royal Highness Princess Margaretha of Denmark, patron of the congress, who personally greeted many members. She was accompanied by the Countess Bernadotte of Sweden who has supported occupational therapy for many years. Their arrival was announced by the blowing of two trumpets dating back to the Viking Age.

Two other outstanding events were the receptions tendered to members by the City of Copenhagen in the magnificent town hall and by the Ministry of Education in the Ny Carlsberg Glyptotek Museum.

The formal congress banquet was held in the Ingenorforeningen or Engineers Club which is the organization for the civil engineers of Denmark. It was one of the few buildings bombed and largely destroyed during the war and has been reconstructed in modern functional design. The decorative menus added a delightful touch with their hand-done covers with designs of delicate pressed flowers. The artistry of the Danes was also evident in the enameled ashtrays presented during the evening to each guest. The banquet was followed by a fashion show of furs presented as the guests sat around coffee tables in the lovely lounges.

WFOT was host to all at the final party which was held in Deer Park which forms part of the King's Park and vast hunting grounds, now open to the public. Two thousand deer roam the wooded areas where no autos are allowed and horse-drawn carriages transport visitors. A gay and hilarious evening was spent with a Chinese auction adding a bit more to the coffers of WFOT. This was made possible through the donation of some exquisite products from Mrs. Kamala Nimbkar, delegate from India.

On the last evening the many students from all over the world were guests of the students of the Danish School of OT at a garden party in the school grounds. Last, but not least to be mentioned, are the visits to the famous Tivoli Gardens to which members went during unoccupied moments. So, it was not all work and no play.

*Message from a Student**

The Danish people are masters at the art of making one feel right at home. Where most people will ply you with wine, the Danes will fill you with delicious Danish pastry and coffee and spend hours talking with you.

The warmth of the Danish home seems to be carried over into all phases of their daily lives, because the congress itself was infused with the same sincerity. Even when more than 700 persons appeared at the congress doors, a number much greater than originally anticipated, our Danish hostesses maintained their welcoming smiles.

The official opening of the congress was Monday morning, August 11, and this day was devoted to introductions and giving everyone the opportunity to meet their friends from all over the world. I was particularly thrilled to meet students and therapists from countries where I never had thought OT existed. It was quite a revelation when I discovered that OT was being practiced in Nigeria.

The remainder of the week was devoted to group discussions, film presentations and lectures concerned with the development and progress of OT in all its phases, plus one day which was spent visiting various hospitals and seeing the sights in and around Copenhagen. The lectures given were concerned with five specific areas of OT: the rehabilitation of the physically disabled, the rehabilitation of children, psychiatry, neurology and geriatrics. Doctors as well as OT's contributed their knowledge.

The congress succeeded in being an ideal place for the international exchange of ideas. One of the most outstanding trends shown on an international level was that OT is striving all over the world to break away from the traditional impression that it is concerned with crafts, and crafts only. OT, as cited by many lecturers, is becoming more and more scientific.

The Danish OT school held a party for all the students at the congress. Here the international cultural exchange was complete. Each country gave a little performance, usually a folk dance or song. By the end of the evening, we had all joined in a Norwegian folk dance, a Swiss song, a song from Ghana, the U.S.A. hokey-pokey and many others. The party gave the final touch to a week filled with making new acquaintances and friends.

*Ann Bernstein, senior, Columbia University.

Last Call . . . Lights . . . Action . . .

AOTA Conference

HOTEL NEW YORKER, NEW YORK CITY
OCTOBER 17 - 24, 1958

Your playbill preliminary program, *Newsletter* and *AJOT* communications can only give you a hint of the excitement that's in store for you at the 1958 AOTA conference in New York City. The air in New York is fairly vibrating with every fascinating area that concerns communications. The roster of speakers and studio personalities is replete with eminent authorities who speak our language and can bring us "up-to-date" in communications—where it be in OT settings, the community or our nuclear age.

On the first day, Mr. Seymour Robins will give a demonstration-lecture that will be a "mood-setter" for the institute-conference. Mr. Robins, whose field is graphic and industrial design, has worked closely with Dr. Adelbert Ames and Dr. Hadley Cantril of the Princeton Perception Laboratories on the subject of visual perception. He designed the Perception Demonstration Center at Princeton and has been consultant in design to the psychology department there. He has demonstrated perception apparatus at universities, art schools, museums and industrial groups throughout the country. Several highway safety devices for which Mr. Robins holds patents are based on concepts resulting from his work in perception.

Mr. Robins' demonstrations will illustrate certain perceptual distortions and explain some of the reason for difficulties encountered in communication. He will describe fundamental processes of interaction and cite causes for differences in perception. This is our opportunity to experience various phenomena which raise a number of questions regarding our own perceptions.

Following this lecture-demonstration, you will have the opportunity to experience what occurs as messages are transmitted from person to person. The "rumor clinic" should be both instructive and entertaining.

Have you ever stopped to think how we as occupational therapists are equipped to help if disaster—natural, accidental or man-made—should strike our community?

Lt. Col. Joseph David Goldstein, M.D., chief of the Department of Atomic Casualties Studies in Washington, D. C., will speak from his wide

Mr. Robins

—Walter Reed Army Inst.
Col. Goldstein

—Blackstone Studio
Dr. Alpenfels

Dr. Swinyard

experience in civilian practice as well as in the armed forces. During two wars he has concerned himself with problems of the destruction of conventional warfare and, more recently, has devoted himself to the widespread problems which would follow in the wake of nuclear warfare. This will be an opportunity for us to take stock of what occupational therapy can offer should an emergency ever arise.

Our "panel of experts" will give us an idea of the scope and broad application of communication techniques. The point of view of the anthropologist, the psychologist, the neurophysiologist, the mass media expert will be presented.

Dr. Ethel J. Alpenfels of New York University is a nationally recognized authority on anthropology and social behavior. She has done research among the Modoc Indians and has made a study of the Haida Indians of Queen Charlotte Island, British Columbia, besides conducting a three-year research on "Will Facts Change Attitudes?" under the auspices of the National Conference of Christians and Jews. Dr. Alpenfels is the author of *Sense and Nonsense About Race* and *Brothers All* which are books widely used by study groups, and her monograph, "The Human Hand," has received world-wide circulation.

We are particularly fortunate in being able to look forward to Dr. Alpenfels' participation on the panel as well as in a "studio" presentation. The studio demonstration called "Man Makes Himself" will be concerned primarily with linguistics and cultural factors in communication.

Jon Eisenson, Ph.D., professor of speech, Queen's College; director of Queen's College speech and hearing center; president of the American Speech and Hearing Association for 1958, is also a member of the panel of experts and will cover psychological aspects of communication.

Chester A. Swinyard, Ph.D., M.D., is another participant both on the panel as well as in a studio demonstration. Dr. Swinyard's distinguished career began as an academician in the department of zoology and department of anatomy at the University of Minnesota and Minnesota College of Medicine. He was also professor of anatomy at the University of Utah College of Medicine and subsequently medical director of the Rehabilitation Center, University of Utah College of Medicine. He is presently engaged as clinical lecturer in physical medicine and rehabilitation at New York University-Bellevue Medical Center—a post he has held since 1956. Dr. Swinyard's studio presentation will include the consideration of speech and hearing defects from a neuroanatomist's point of view.

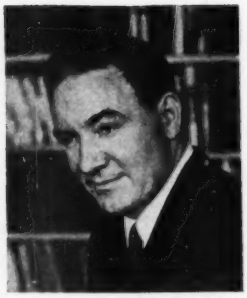
Dr. Morton A. Seidenfeld has been chief of psychological services division of the National Foundation since 1945. In this position his experience has included that of using mass media in health education programs and we will be especially interested in techniques applicable to occupational therapy. Dr. Seidenfeld will point out assets and liabilities in using mass media.

Dr. Seidenfeld

Dr. Seidenfeld's bibliography consists of some 57 published articles in psychological, medical, educational and psychiatric journals. His former posts have been: co-director of the psychological clinic of St. Christopher's Hospital for Children in Philadelphia, director of psychological services and rehabilitation at National Jewish Hospital in Denver, director of rehabilitation at the Tuberculosis Hospital of Chicago, and chief clinical psychologist, Office of the Surgeon General, U. S. Army.

After the panel presentation, at least seventeen "studios" will be set up for small group demonstrations. These will further elaborate and demonstrate those aspects of communication as they may be related to the treatment of patients, inter-relationships with staff, community, etc. Be

—David Workman
Mr. Tibbs



—Edith Worth
Mr. Jennings

prepared to make some very difficult choices, for each studio will be different and each will have an outstanding expert demonstrating communication techniques or exploring some facet thereof.

Besides the two already mentioned (Dr. Alpenfels and Dr. Swinyard), others include the following:

Thomas S. Tibbs will be concerned with the tactile aspect of perception. Mr. Tibbs is the director of the Museum of Contemporary Crafts in New York City. Mr. Tibbs' achievements noted in *Who's Who in America, Who's Who in the East* and *Who's Who in American Art* are far too numerous to list, but his promotion of interest in art and in the field of decorative arts and crafts is well known and of particular interest to occupational therapists. He has been juror of numerous national and regional exhibitions and is best remembered by New York occupational therapists for his stimulating talk which he gave in the setting of his marvelously atractive Museum of Contemporary Crafts.

Frank G. Jennings is the executive director of the Library Club of America. Mr. Jennings has held various teaching posts at New York University, University of Denver, Yeshiva University in New York City and Teacher's College, Columbia University. At Teacher's College he conducted a graduate seminar on professional writing, and his publications include a pamphlet called "Hidden Hungers: The Care and Feeding of the Young Reader," as well as a number of articles in educational and literary magazines. Mr. Jennings' studio will be concerned with "Language as a Barrier, and Language as a Medium."

Richard G. Kraus is associate professor at Teacher's College, Columbia University, in the department of health education, physical education and recreation, in charge of courses in dance and social recreation skills. From 1955 to 1958 he was a dance specialist at New York Hospital, Westchester Division. Professor Kraus' studio will emphasize adult recreation, and he is well known for his books in that field: *Square Dance of Today, Recreation Leader's Handbook, Play Activities for Boys and Girls.*

Mr. Kraus

Theodore Jackson, Ph.D. in psychology, is the director of psychological services of Stevenson, Jordan and Harris, a firm of industrial engineers, or "efficiency experts." Bodily posture, facial expressions and other non-verbal aspects of communication will be included in the demonstration and discussion.

Dorothy Voss, PT, has asked for an occupational therapist, a patient and a loom to demonstrate the application of the technique of proprioceptive facilitation as applied to occupational therapy. Miss Voss, presenting this demonstration of the advantages of OT-PT "reciprocal" process, is the consultant-director of the chapter and membership department of the American Physical Therapy Association and is well known to many occupational therapists.

Miss Marion Reisenwebber, educational psychologist at the Institute for the Crippled and Disabled in New York City, calls her demonstration "What Do You Mean?" Miss Reisenwebber, who has been a kindergarten teacher, first grade teacher, school psychologist and guidance teacher, will illustrate learning cues of the brain injured. She is the author of an article which appeared in *Psychological Monograph* on "The Use of Modified Block Designs in the Evaluation and Training of the Brain-Injured."

Mr. Walter L. Brown is an art therapist at Rockland State Hospital in Orangeburg, New York. Mr. Brown will describe and demonstrate psycho-iconography as a method of psychotherapeutic communication. An article, "Psycho-iconography of the Office Neurotic," was published in *Clinical Symposia.*

Mr. H. V. Munchausen, an acoustical engineer, will demonstrate and speak on the helpful or disturbing effects of environmental noises. Mr. Munchausen is the president of the Munchausen Soundproofing Company of New York City.

Dr. Dan W. Dodson, professor at New York University, is a specialist in intergroup relations and director of the Center for Human Relations and Community Studies. He has contributed to the surveys of numerous school systems in New York City by leading phases of the studies that dealt with population movements and community backgrounds. He also served as director of the mayor's committee on unity in New York City from 1944 to 1948. Dr. Dodson's subject in his studio will be "Values."

—Signal Corps, Walter Reed

Col. Robinson

—Walter M. Faust

Miss Willard

Irmgart Bartenief, PT, Institute for the Crippled and Disabled in New York City, will give us an idea of "Sensory-Motor Experiences in Dance."

Addison Bennett of the United Hospital Fund will draw from his experience in the use of mass media to illustrate intercommunication within the organization.

Just about the time our brains and vocal cords have become a bit weary, we get to "eavesdrop while our leaders talk it over." What could be better than listening to our president and president-elect talking things over—especially when they are Lt. Col. Ruth A. Robinson, O.T.R., and Helen S. Willard, O.T.R., respectively. We will share their reactions to the conference-institute.

If you've ever been to a meeting or discussion group with Col. Robinson, you know just how succinctly and gracefully she gets to the heart of the matter and how creatively her mind works. Col Robinson has been chief of the OT section at Walter Reed Army Hospital, Washington, D. C., since 1955. A graduate of the Boston School of Occupational Therapy, she has the distinction of being the first person to be chief of the OT section in the Army Specialist Corps. Before entering the service Col. Robinson was chief occupational therapist at the Community Work Shops in Boston.

Miss Helen S. Willard is perhaps best known to occupational therapists as editor of *Principles of Occupational Therapy,* and in a more personal way is graciousness, competence and good sense personified.

Miss Willard has been director of the Philadelphia School of Occupational Therapy since 1935 and professor of OT in the School of Auxiliary Medical Services at the University of Pennsylvania since 1950. Few women have had careers as colorful and successful as hers. She worked with Dr. Harry E. Stewart on one of the first physical therapy textbooks in 1918; she was chief physical therapist in US Public Health Service Hospital in 1921; and was assistant superintendent of reconstruction aides, Office of the Surgeon General, in 1922.

Miss Willard has the honor of being named "Woman of Achievement" by the Exposition of Women's Arts and Industries in 1948, "A Distinguished Daughter of Pennsylvania" in 1954, and also received the AOTA award of merit in 1954.

The conference-institute dates are: October 17-24, 1958. You can't afford to miss this conference.

NFIP REORGANIZES

Now that the fight against paralytic poliomyelitis is well on its way to success, the National Foundation for Infantile Paralysis has dropped the reference to a specific disease in its title. It will be known in the future as the National Foundation whose concept for the future envisages an organized force in the fields of medical research, patient aid and professional education with specific goals initially but flexible enough to meet new health problems as they arise.

The first new goals will be research and eventually a patient aid program in arthritis and congenital malformations. Virus research will be continued and expanded as will the investigations currently being conducted into the disorders of the central nervous system.

The new program was adopted after five years of exhaustive investigations of areas of need in the health field and careful assessment of the strengths of the National Foundation that could be applied to other problems. Conferences were held with medical, civic and governmental leaders, as well as with representatives of National Foundation Chapters from all regions of the country. The Board of Trustees approved the program on May 28, 1958.

The keynote of the National Foundation's future program will be research. At this moment virologists have uncovered clues pointing to problems little dreamed of ten years ago. Freedom to follow research clues wherever they lead will be combined with necessary limitations on patient aid in the beginning.

The limitations result from the enormity of the problem: at least 11,000,000 persons have arthritis and rheumatism; 250,000 children are born each year with significant congenital malformations (excluding birth injuries), and an estimated 150,000 persons who have had paralytic polio will require some assistance in the years ahead.

The National Foundation plans to offer patient aid at first only to arthritis patients through 18 years of age and to children suffering from malformations of the central nervous system, also

through age 18. Rheumatoid arthritis, the most serious of the rheumatic cripplers, annually affects an estimated 30,000 children and adolescents of whom some 16,000 can be expected to seek treatments each year. It is planned to work primarily with this group in the beginning because the most good can be done for them and the most learned of benefit to all arthritis sufferers.

Some 8,000 patients with treatable defects of the central nervous system will also be aided. Among these conditions are spina bifida, encephalocele and hydrocephalus. Although children with congenital mental retardation will not be among those aided, there is strong evidence that the research programs now under way will contribute to ultimate prevention and treatment of this problem.

Achievements in the rehabilitation of severely disabled polio patients will have renewed meaning when these professional skills are applied to arthritis patients as well as to persons handicapped by congenital malformations.

The National Foundation's professional education program of tomorrow will continue its flexible structure, functioning essentially through the channels of scholarships and fellowships; assistance to professional schools, associations and agencies and production and distribution of research and teaching aids.

Psychiatric Activity . . .

(*Continued from page* 242)

"So relationship should be healthy and not develop a crutch for Mrs. Jones, who would become more demanding."

No mention was made in the story that this relationship would not be beneficial for Mrs. Jones. The respondent's assumption is not in the spirit of the test. It might be assumed that attention would make her less demanding.

Some illustrations of "wrong" answers were given for "good" reasons. One person, who checked "d" in Question 5 said that he thought that this closeness to Mrs. Jones was a good thing, because it was a sign that the aide was capable of warmth and closeness to patients. While this answer is in sympathy with the test as a whole, the story does not really support a "d" answer. Not enough information is given regarding Mrs. Jones to determine whether it was Mrs. Jones or only the aide's own needs that were being considered. There is also the problem of the needs of other patients who might be neglected because of this situation.

Another respondent wrote: "It is easy for a new aide to single out one patient because the aide herself feels so new and strange that Mrs. Jones' needs help her feel more comfortable."

While this may be true, it fails to take into account the possible drawback to this kind of involvement, or suggest what could or should be done about it. However, even though the answer could not be considered "correct" it showed the respondent aware of staff's feelings and problems that should be considered.

SUMMARY AND CONCLUSIONS

A questionnaire concerning attitudes toward activity therapy has been presented. It consists of problems that might occur in the daily life of any activity therapist working in a psychiatric setting, together with various alternative courses of action among which the respondent was to choose. Correct choices were deemed to reflect attitudes which would make the therapist's behavior more beneficial to the patients under his care.

Professionally trained therapists and those with more education demonstrated greater success on this task, demonstrating more sophistication, at least in theory.

Experience alone appeared to add less to the therapist's understanding of the problems covered. This implies that the equivalence of experience and training espoused by some must be brought into question. The relative difficulty with some of the items experienced by even the qualified workers points to the need for more careful consideration of overall goals and objectives of activity therapy.

The educational value of this tool seems quite evident. The situations depicted are typical, and the alternatives sufficiently plausible to provoke much discussion. Further research with this questionnaire or similar devices can help to bridge the gap between theory and practice, and produce a field of activity therapy in which art and science will be merged for the greater benefit of the maladjusted persons under our care.

REFERENCE

1. Schwartz and Shockly. *The Nurse and the Mental Health Patient.* New York: Russell Sage Foundation, 1956.

CORRECTION

A transposition occurred in the formula on Page 141 of the May-June issue. The formula should have read:

$$\left| C A^{-1} C^{T} - \lambda B \right| = 0$$

THE RECOGNITION OF OCCUPATIONAL THERAPY ASSISTANTS

The material developed for the recognition and training of the occupational therapy assistant by the committee for the recognition of occupational therapy assistants is being published in AJOT for the information of the membership.

At the 1957 midyear meeting (April) the Board of Management accepted this report in principle, subject to further review by the council on education, the clinical procedures committee and house of delegates' representatives. At the 1957 annual meeting (October), subsequent to completion of the above review, the report was again presented, and the Board voted to accept the final version incorporating the revisions recommended. You will find these recommendations in the following material.

The plan will be implemented in October, 1958. At that time, a letter announcing the plan will be mailed to state commissioners of mental health and other appropriate agencies and individuals, the complete report will be published in AJOT and a report will be given to the membership at the business meeting of the annual conference. The state association presidents and delegates received the information in June, 1958.

We hope you are pleased with the report which was designed to meet an increasingly imperative need and that you will inform interested personnel of it.

Marianne Catterton
Veronica C. Dobranske
H. Elizabeth Messick
Marian Wright Peoples
Bertha Piper
Ruth A. Robinson, *ex-officio*
Marion W. Crampton, *Chairman*

RECOMMENDATIONS

The committee on recognition of occupational therapy assistants recommends that:

1. The certification team consist of two registered occupational therapists selected by the American Occupational Therapy Association from an area within a reasonable distance of the training facility.

2. The American Occupational Therapy Association reimburse the certification team for actual expenses incurred by them in their visit.

3. The American Occupational Therapy Association publicize all aspects of the plan to recognize and train occupational therapy assistants by notifying state departments of mental health, state and private psychiatric hospitals, the physical medicine and rehabilitation section of the department of medicine and surgery of the Veterans Administration, the American Psychiatric Association, the National Association for Mental Health and other appropriate agencies and individuals.

4. The education office be charged with the responsibility of:

a. Handling the occupational therapy assistant program.

b. Sending pertinent material upon request from interested training facilities.

c. Holding workshops to prepare occupational therapists for making certification visits.

d. Obtaining the services of a consultant to conduct workshops* for the preparation of instructors of the occupational therapy assistant programs.

*It may be wise to consider holding these during or at the time of the midyear and annual meetings.

5. The committee on recognition of the occupational therapy assistant shall:

a. Collaborate with the education office in:

1) Processing applications pertinent to the occupational therapy assistant programs.

2) Conducting the workshops (i.e., 4c&d).

b. Be charged with follow-up on the type of work performed by occupational therapy assistants certified on completion of an approved training program until the function of personnel trained at this level can be satisfactorily defined.

6. The American Occupational Therapy Association be responsible for setting and collecting the application, certification, and insignia fees; that monies so collected be used to defray the expenses involved in the project.

7. The whole procedure of certifying occupational therapy assistants and developing training programs from the psychiatric curriculum guide be used as a pilot study and evaluated before curriculum guides for other disability areas are developed.

8. The fee for assistant member in AOTA be set at $8.00 and the assistant membership benefits include the Newsletter, advisory services and a subscription to AJOT.

9. That each training program should be set up to cover only one particular disability area and that the assistant be certified in that area.

10. That certification insignia be made available by the American Occupational Therapy Association to:

a. Graduates of approved programs; initial insignia to be obtained by the director of the training program from the American Occupational Therapy Association.

b. Those who have worked a minimum of two years in one disability area prior to the establishment of national standards and have satisfactory recommendations from three qualified individuals, one of whom must be a registered occupational therapist under whom applicant is working.

11. That this grandfather's clause be eliminated three years from the date of establishment of training standards by the American Occupational Therapy Association.

12. That a permanent committee for the recognition of the occupational therapy assistant be established.

13. That membership of the committee on recognition of the occcupational therapy assistant be composed of at least one representative from the council on education's committee on curriculum and one from the committee on student affiliations; one representative from each subcommittee of the committee on clinical procedures whose disability area has developed a program for endorsement;

any additional person(s) whom the chairman invites to serve.

14. That the application form for the endorsement of the training program be turned over to the committee on recognition of the occupational therapy assistant.

15. That consideration be given to the establishment of a program through the resources of the Southern Regional Education Board and the Western Interstate Commission for Higher Education where facilities may not be available in each state to meet the minimum requirements of the training program for assistants.

The project committee recognizes the following advantages and problems to be considered in giving this personnel a voice in the affairs of the Association and voting privileges on a fractional basis:

Problems of the Occupational Therapy Assistant

Attitude of the assistant toward the registered occupational therapist.

Amount of voice to be granted.

Advantages to Occupational Therapy Assistant

Provide means of communication.

Provide means of unification.

Broaden knowledge and experience.

Give status.

Give recognition.

Give support.

Increase feeling of belonging through participation.

Problems of the Association

Attitude of the registered occupational therapist toward the assistant.

Ratio of active members to the assistant.

Mechanics of fractional voting.

Advantages to the Association

Provide means of communication.

Provide means of unification.

Provide a better quality of service to patients.

Extend services to greater number of patients.

Provide better vital statistics concerning occupational therapy service.

Provide more revenue to increase service to membership.

The project committee offers the following recommendations:

1. That this type of personnel be called occupational therapy *assistants.*

2. That Article II, Section 1 on Members of the Constitution of the American Occupational Therapy Association be revised to include this personnel and that it be inserted between "students" and "associate." This section of the constitution would then be read as follows: 1. Active: 2. Fellows: 3. Student: 4. *Assistants: those who are certified occupational therapy assistants.* 5. Associates: 6. Sustaining: 7. Honorary:

3. That this category of personnel *not* be given a direct vote in the affairs of the American Occupational Therapy Association and have no representative in the House of Delegates or on the Board of Management as such.

4. That the fee for membership be more than for students and less than for active membership.

5. That the Board of Management of the American Occupational Therapy Association determine the membership benefits for the assistant category; that these benefits be *less* than those available to the active members and *more* than those available to the associate members.

REQUIREMENTS OF AN ACCEPTABLE TRAINING PROGRAM FOR OCCUPATIONAL THERAPY ASSISTANTS

Preamble

The American Occupational Therapy Association endorses these requirements for the preparation of occupational therapy assistants. The committee on recognition of occupational therapy assistants serves as a consulting, reviewing and evaluating body working in conjunction with the education office of AOTA.

Occupational therapy assistants are trained to work under the supervision of registered occupational therapists in the facility.

I. *Organization*

1. Assistant programs should be established in the types of hospitals or agencies which may require their services. The hospitals should be approved by the Joint Commission on Hospital Accreditation.

2. There should be a local advisory committee comprised of occupational therapists, physicians and members of allied disciplines. The terms of these committee members should be at least three years and overlap.

II. *Resources*

3. The training program should have assurance of adequate financial support for effective implementation.

III. *Faculty*

4. The faculty for an approved training program for occupational therapy assistants should include a minimum of three registered occupational therapists for a class of 15 students or less. One of these should be the director of the program. One registered occupational therapist should be added for every additional 15 students.

IV. *Plant*

5. The classroom facilities should include adequate lecture rooms, workshop areas and administrative offices. Adequate equipment for efficient teaching should be provided.

6. A combined library and study room of adequate space and availability should contain books, pamphlets and periodicals to supplement classroom teaching. Provision should be made for annual additions and subscriptions to periodicals.

V. *Administration*

7. *Supervision.* Established standards of the training program should be effectively maintained by its director or committee in charge.

8. *Credentials.* The admission of trainees to the program of instruction should be in the hands of a responsible committee or examiner. Data on the trainees' preliminary education should be obtained and kept on file.

9. Records on qualifications of the faculty should contain information on general and professional education, professional experience and membership in professional organizations.

10. *Records.* There should be easily available, current records of trainees and graduates. Trainee records should contain information on credentials, health, attendance, grades and suitability for work in the particular disability area.

11. *Number of Trainees.* The number of trainees accepted for the training course should be limited by the facilities of the hospital or agency.

For practical experience in workshop areas, a single instructor can usually supervise about fifteen trainees. It is essential for trainees and faculty members to have opportunity for close personal contacts. Every training center should reserve the right to drop a trainee at any time for any cause which the faculty and administration deem sufficient.

VI. *Publications*

12. The institution offering the program should issue an appropriate pamphlet or outline of the training program. This should be reviewed and brought up to date at least biennially.

VII. *Prerequisites for Admission*

13. *Education.* Candidates should have a minimum education of senior high school graduation or high school equivalent. (Satisfactory job experience and appropriate recommendations may be substituted for two years of education.)

14. *Health.* All candidates should be in good physical and emotional health.

15. *Age.* The minimum age for candidates should be eighteen years. Applicants over fifty-five years of age would not ordinarily be accepted unless exceptionally well qualified.

16. *Personality.* Applicants should be intelligent, mature, emotionally stable, flexible, cooperative and have the ability to establish and maintain effective interpersonal relations.

VIII. *Curriculum*

17. *Length of course.* The length of the program should be a minimum of 12 weeks (460 clock hours) of didactic instruction, specialty skills and supervised practical application.

The period devoted to didactic instruction and specialty skills should include not less than 300 clock hours of which not less than 140 clock hours should consist of didactic instruction in skills related or essential to the area of specialty training.

IX. *Centers for Practical Application*

18. Hospitals or agencies conducting the training program may integrate the didactic instruction and practical application within their own center.

19. Where the practical application is not given within the same hospital or agency, the centers used for this purpose should be carefully selected by the director of the training program.

a. No occupational therapy department should be considered as a center for practical application unless the person who serves as supervisor is a competent, registered, occupational therapist, qualified to supervise students.

b. Supervisors of the students during practical application should be familiar with the content of the courses in the training program for effective correlation of the didactic instruction and practical application.

c. Each associated hospital or agency should have a well defined program to give the trainee practical experience in the function of an occupational therapy assistant in one specialty area.

d. Pertinent information on the trainees should be sent to the center where the trainee receives practical experience prior to his arrival.

e. Records covering the trainee's performance and adjustment should be sent to the training program director on completion of the period of practical experience.

X. *Endorsement Procedure*

20. Training programs for occupational therapy assistants must be endorsed by the American Occupational Therapy Association to enable the graduates of such programs to apply for certification as occupational therapy assistants. Visits to the hospitals or agencies conducting these training programs will be made by official local or regional representatives of the Association.

21. Application forms for the endorsement of the training program may be obtained from the education office of the American Occupational Therapy Association, 250 West 57th Street, New York 19, New York. This should be completed and returned with the application fee together with a syllabus of the training program developed from the American Occupational Therapy Association's outline.

22. Tentative approval may be given to the program until arrangements have been made by the committee for representatives to make the approval visit at a mutually convenient time.

23. A minimum of one full day should be planned for surveys. Additional time will be needed if there are several affiliation centers to be visited. Arrangements should be made for the following:

a. Conference with the director or committee in charge.

b. Conference with faculty members to discuss training program.

c. Conference with advisory committee if deemed advisable by the director or committee in charge.

d. Visits to classroom facilities, workshop areas, and the combined library and study room.

e. Visits to associated hospitals or agencies, if any are used.

f. Monitor sessions in the application of occupational therapy.

g. Review appropriate records.

24. Following the endorsement visit, copies of the project committee's action with recommendations will be sent to the hospital or agency.

25. An annual report form will be sent to each approved training center. This should be completed and returned to the American Occupational Therapy Association.

26. Re-approval of the program, following the pattern of the initial survey, should be obtained every three years. Previous recommendations, changes in curriculum and the interim annual reports will be considered.

GUIDE IN THE MECHANICS OF HANDLING A TRAINING PROGRAM

Faculty

1. One registered occupational therapist would be the coordinator of the program or a member of the coordinating committee planning the program and integrating all phases. One registered occupational therapist, preferably a different faculty member, would be the program advisor and would be responsible for making himself available at least for a specified period each day when the students would be encouraged to bring him any questions or problems arising out of the program. He would also be responsible for having a discussion period following any training films presented unless this should be handled by another member of the faculty.

2. One registered occupational therapist would conduct a course in the application of activities to the disability area for which the course is being conducted.

3. At least one licensed physician should conduct lectures, discussion groups and/or clinics for the trainees in the given disability area.

4. The types of specialists invited to participate in the training program, and their qualifications, should be determined by the appropriate subcommittee of the American Occupational Therapy Association's committee on clinical procedures.

5. A member of the faculty should be responsible for monitoring all classes given by other specialists.

Centers for Practical Experience

6. A satisfactory rating in the period of practical application is essential to be eligible to receive the insignia.

7. The training ratio of one registered occupational therapist to two trainee occupational therapy assistants is desirable.

CURRICULUM GUIDE FOR OCCUPATIONAL THERAPY ASSISTANTS

PSYCHIATRIC AREA

Foreword

The field of medicine is dedicated to the treatment and cure of emotionally and physically ill individuals. Occupational therapy is one of the many disciplines making a significant contribution towards returning these people to society as contributing members. "In a number of ways the occupational therapist has an advantage over the psychiatrist in studying patients. The occupational therapist deals with patients in a much greater variety of situations, in situations which are far more natural, far more like the world outside the hospital (the important world after all) and in situations which are far less formalized than either the psychiatrist's interview room, the psychologist's testing room or the physiologist's laboratory. As Dr. Robert Hyde pointed out,[2] 'the nearer tests of human motivation, ability, and function can reduplicate the actual life situations, the more valid they are. The prime purpose of such tests is to measure how an individual functions in life situations. The occupational therapy department can serve as a research laboratory wherein a reduplication of life situations is organized.' "[1]

In order to render the most effective service, occupational therapy must continually be alert to changing concepts, including the dynamics of human behavior and emotions. Furthermore, the occupational therapist must endeavor to understand, first, himself that he may better ascertain his own fitness for the job. Each individual has certain interests and skills already acquired that can be therapeutically beneficial when brought to the patient in the proper setting and used with an understanding of the needs of the patient. The occupational therapist's status in the all important therapist-patient interpersonal relationship requires maturity of attitude and stability of personality.

One of the major problems confronting the medical profession today is the shortage of trained personnel. In the light of this serious situation, therefore, the registered occupational therapist must accept increasing responsibility for leadership. He is the logical person to act as an administrator in the planning and execution of integrated activity programs. He offers advice to the assistants and shares his knowledge of activity techniques with them in their work with patients and personnel. He discusses with them the doctors' referrals of patients to the occupational therapy clinic. The attention and energies of both the therapist and assistant are focused on the special needs of the patient and on the supportive role of occupational therapy for somatic, chemo-, and other therapies. A well planned, in-service training course for occupational therapy assistants will help to make such programs more effective.

It is expected that the curriculum guide contained in the following pages will provide a means whereby the professional occupational therapist can develop a detailed program for preparing occupational therapy assistants to help the occupational therapy staff assume a more efficient role and, hence, to offer greater service to patient, hospital and physician.

The didactic hours as indicated on the following pages are offered as a guide only.

1. D. Wells Goodrich, M.D. "Research in Psychiatric Occupational Therapy." **The American Journal of Occupational Therapy,** January-February, p. 2, 1952.

2. Hyde and Scott. "The Occupational Therapy Research Laboratory." **Occupational Therapy and Rehabilitation,** June, 1951.

Unit I: 1 *Hour*

Topic: Introduction to training program.
Material Covered
1. Living facilities, hours and meals
2. Transportation
3. Recreational facilities
4. Etcetera

Suggested Techniques
1. Coffee hour with welcome by appropriate personnel. (Reasons for offering course should be included.)
2. Informal discussion.
3. Distribution of printed matter concerning routine procedures, e.g., laundry, meal hours, transportation schedules, eating places in area.

Unit II: 1 *Hour*

Topic: Aim, purpose and scope of program.
Material Covered
1. Introduction to concepts of the profession of occupational therapy.
2. Organization: national and state levels; training requirements for occupational therapists; supportive data concerning the advantages of occupational therapy to the patient.
3. The need for occupational therapists and occupational therapy assistants; brief statistical information on number of schools, number of graduates per year, job opportunities.
4. Explanation of course content; assignments.

Suggested Techniques
1. Lecture and discussion.
2. Distribution of printed matter including organizational chart, word list, reading list, requirements.

References

1. "Facts about Occupational Therapy." American Occupational Therapy Association.
2. **The Objectives and Functions of Occupational Therapy,** pp. 111, IV, VII, VIII. New York: American Occupational Therapy Association, 1956.
3. Fidler, Gail S. and Jay W. **Introduction to Psychiatric Occupational Therapy,** pp. 1-4. New York: Macmillan Co., 1954.
4. Fidler, Gail S. "The Role of Occupational Therapy in a Multi-Discipline Approach to Psychiatric Illness." **The American Journal of Occupational Therapy,** XI:1 (January-February) 1957, pp. 8-12.
5. Greenblatt, Milton, Richard H. York and Esther L. Brown. **From Custodial to Therapeutic Patient Care in the Mental Hospitals,** pp. 1-25. New York: Russell Sage Foundation, 1955.
6. **Occupational Therapy-Manual of Reference for Personnel,** pp. 1-8. Albany: NYS Department of Mental Hygiene, 1956.
7. Willard, Helen S. and Clare S. Spackman, eds. **Principles of Occupational Therapy,** 2nd edition, pp. 11-23. Philadelphia: J. B. Lippincott Co., 1954.

Unit III: 46 *Hours*

Topic: Orientation to hospital services

Material Covered	*Suggested Approaches*
1. Chaplaincy service	Lecture and discussion
a. Role and function	
b. Areas for collaboration with occupational therapy	
2. Industry	Lecture and discussion
a. Role and function	Tour of industries
b. Areas for collaboration with occupational therapy	
3. Legal aspects of hospitalization	Lecture and discussion
a. Commitment laws (sections, hearings)	
b. Rights: those lost those retained	
c. Hospital absences (escape, visit, transfer)	

d. Number of admissions and discharges for current year (at institution where training course is given) e. Cost of patient care; how handled	
4. Library (patients') a. Role and function b. Areas for collaboration with occupational therapy	Lecture and discussion
5. Medical services a. Organization b. Function of entire medical services	Lecture and discussion Tour of services
6. Music a. Role and function b. Areas for collaboration with occupational therapy	Lecture and discussion Demonstration
7. Nursing a. Role and function b. Areas for collaboration with occupational therapy	Lecture and discussion
8. Occupational therapy a. Role and function of registered occupational therapist b. Role and function of occupational therapy assistant	Lecture and discussion
9. Psychology a. Role and function b. Areas for collaboration with occupational therapy	Lecture and discussion Participation in sampling of testing procedures
10. Public relations a. Role and function b. Areas for collaboration with occupational therapy	Lecture and discussion Printed material
11. Recreation a. Role and function b. Areas for collaboration with occupational therapy	Lecture and discussion
12. Social service a. Function and relationship to hospital b. Function and relationship to community (Outpatients, area mental health clinics) c. Interagency procedures (old age assistance, division of employment security, vocational training) d. Areas for collaboration with occupational therapy	Lecture and discussion
13. Volunteers a. Role and function b. Areas of service c. Areas for collaboration with occupational therapy	Lecture and discussion
14. Other	Lecture and discussion A session with the occupational therapist might take place following each lecture in order to amplify on areas for collaboration with occupational therapy

References

1. "ANA Statement of Functions." **American Journal of Nursing,** 54:7 (July), pp. 868-871, 1954.
2. "ANA Statement of Functions." **American Journal of Nursing,** 54.8 (August), pp. 994-996, 1954.
3. Davis, Ida J. **Handbook for Volunteers in Mental Hospitals.** Minneapolis: University of Minnesota Press, 1950.
4. Davis, John Eisele. **Clinical Applications of Recreational Therapy.** Springfield, Ill.: Charles C. Thomas, 1952.
5. Dunton, William R. and Sidney Licht, eds. **Occupational Therapy: Principles and Practice.** Springfield, Ill.: Thomas, 1950.
6. Harrower, Molly. **Appraising Personality: the Use of Psychological Tests in the Practice of Medicine.** New York: W. W. Norton & Co., 1952.
7. "Psychiatric Social Work in the Psychiatric Clinic," Group for the Advancement of Psychiatry, 1790 Broadway, New York.
8. "Statement of Functions of the Nonprofessional Worker in Psychiatric Nursing," **American Journal of Nursing,** 55:3 (March), pp. 336-337, 1955.
9. "The Psychiatric Nurse in the Mental Hospital," Group for the Advancement of Psychiatry.
10. "The Psychiatric Social Worker in the Psychiatric Hospital," Group for the Advancement of Psychiatry.

Unit IV: 12 *Hours*

Topic: Personality development

Material Covered

1. Stages of psychosexual development
2. Manifestations of behavior
3. Ego mechanisms

Suggested Approaches

1. Lecture and discussion
2. Visual aids
3. Records (Phonograph)

References

1. Balser, Benjamin H., ed. **Psychotherapy of the Adolescent.** New York: International Universities Press, 1957.
2. English, O. Spurgeon and G. H. J. Pearson. **Emotional Problems of Living.** New York: W. W. Norton & Co., 1945.
3. Katz, Barney and Louis P. Thorpe. **Understanding People in Distress.** New York: Ronald Press Co., 1957.
4. Leary, Timothy. **Interpersonal Diagnostics of Personality.** New York: Ronald Press Co., 1957.
5. Menninger, William and Leaf Munroe. **You and Psychiatry.** New York: Scribner's, 1948.
6. Mezer, Robert. **Dynamic Psychiatry.** New York: Springs Pub. Co., 1956.
7. Rowe, Clarence J. **An Outline of Psychiatry.** Dubuque, Iowa: Wm. C. Brown Co., 1954.
8. Mental Mechanism Films. New York: National Film Board of Canada.
9. Mental Mechanism Records: Topeka, Kansas; Menninger Foundation.

Unit V: 3 *Hours*

Topic: Diagnostic nomenclature

Material Covered

1. Classifications and etiology
2. Symptomatology
3. Correlation with dynamic psychiatry
4. Relation of diagnostic nomenclature to the law

Suggested Approaches

1. Lecture and discussion
2. Observation

References

1. **Diagnostic and Statistical Manual, Mental Disorders.** Washington, D. C.: American Psychiatric Assoc., Mental Hospital Service, 1952.
2. Noyes, Arthur P. **Modern Clinical Psychiatry,** fourth edition. Philadelphia: W. B. Saunders Co., 1953.
3. Rowe, Clarence J. **An Outline of Psychiatry.** Dubuque, Iowa: Wm. C. Brown Co., 1954.

Unit VI: 3 *Hours*

Topic: Treatment

Material Covered

1. Group therapy
2. Psycotherapy
3. Chemotherapy
4. Convulsive therapy

Suggested Approaches

1. Lecture and discussion
2. Visual aids
3. Observation

References

1. Slavson, Samuel R. **The Practice of Group Therapy. New** York: International University Press, 1947
2. Standish, Christopher T. and Elvin V. Semrad. "Group Psychotherapy with Psychotics." **Journal of Psychiatric Social Work,** 20: (June) pp. 136-166, 1951.

Unit VII: 1 *Hour*

Topic: History and philosophy of occupational therapy

Material Covered

1. Earliest references to the concept of occupational therapy
2. First training courses leading to the development of today's profession
3. World War I war emergency courses
4. Establishment of schools of occupational therapy and standards
5. World War II expansion of occupational therapy
6. Occupational therapy on the international level

Suggested Approaches

1. Lecture and discussion
2. Printed material

References

1. AOTA printed material on schools of occupational therapy, registration and standards.
2. Dunton, William R. and Sidney Licht, eds. **Occupational Therapy: Principles and Practice,** pp. 3-15. Springfield, Ill.: Charles C. Thomas, 1950.
3. Willard, Helen S. and Clare S. Spackman, eds. **Principles of Occupational Therapy,** 2nd ed., pp. 1-10. Philadelphia: J. B. Lippincott Co., 1954.

Unit VIII: 3 *Hours*

Topic: Role and function of members of occupational therapy department

Material Covered

1. Duties and responsibilities
   a. Director
   b. Registered occupational therapist
   c. Occupational therapy assistant
   d. Volunteer
   e. Other
2. Professional conduct

Suggested Approaches

1. These sessions might be coordinated with appropriate lectures by members of other hospital services. (see *Unit III, Suggested Approaches:* 14.)
2. Lecture and discussion
3. Group discussion method
4. Printed matter (job descriptions)
5. Role playing

References

1. **The Objectives and Functions of Occupational Therapy,** pp. VII-VIII. New York: American Occupational Therapy Assoc., 1956.
2. Dunton, William R. and Sidney Licht, eds. **Occupational Therapy: Principles and Practice.** Springfield, Ill.: Charles C. Thomas, 1950.
3. Fidler, Gail S. and Jay W. **Introduction to Psychiatric Occupational Therapy,** pp. 12-27. New York: Macmillan Co., 1954.
4. **Manual on Organization and Administration. New York:** American Occupational Therapy Assoc.
5. **Occupational Therapy: Manual of Reference for Personnel.** Albany: NYS Department of Mental Hygiene, 1956.
6. Willard, Helen S. and Clare S. Spackman, eds. **Principles of Occupational Therapy,** 2nd ed., pp. 98-114. Philadelphia: J. B. Lippincott Co., 1954.

Unit IX: 79 *Hours*

Topic: Occupational therapy for the mentally ill

Material Covered	*Suggested Approaches*
1. Method of patient referral to:	Lecture and discussion
a. Department	Attend diagnostic staff conference
b. Occupational therapy assistant	Attend service conference of a particular area
	Occupational therapy conference
2. Presenting behavioral patterns	Lecture and discussion
	Attend interdisciplinary teaching seminar
3. Therapist-patient relationships	Lecture and discussion
	Role playing
	Visual aids
4. Precautions	Group discussion method
5. Selection of media	Lecture and discussion
a. Choice: free, limited, directed	Visual aids
	Demonstration
b. Properties or characteristics	Laboratory
c. Value	
1) Diagnostic aid	
2) Therapy	
3) Re-education and development of work habits	
4) Prevocational exploration	
6. Observation and reporting of impressions of patient's	Lecture and discussion
	Assignment of patient for study
a. Reaction to supervisor	
b. Reaction to other patients	Printed material
c. Reaction to surroundings	
d. Reaction to and performance in activity.	

References

1. Azima, H. and E. D. Wittkower. "Gratification of Basic Needs in Treatment of Schizophrenia," **Psychiatry,** 19: (May) 1956.
2. Azima, H. and E. D. Wittkower. "A Partial Field Survey of Psychiatric Occupational Therapy," **The American Journal of Occupational Therapy,** XI:1 (January-February), pp. 1-7, 1957.
3. Barton, Wheeler E. "Medical Supervision in Occupational Therapy," **The American Journal of Occupational Therapy,** IX:2, Part I (March-April), pp. 53-56, 1955.
4. **The Objectives and Function of Occupational Therapy: Specific Treatment Techniques and Procedures.** New York: American Occupational Therapy Assoc., 1956.
5. "Therapeutic Use of Self," Group for the Advancement of Psychiatry, 1955.
6. Cromwell, J. O. "Dynamic Concepts Underlying the Use and Prescription of Activities Therapy," **Mental Hospitals,** 7:1 (January), pp. 9-11, 1956.
7. Ey, John A., Jr., Capt. MSC. "Techniques and Psychology of Instructing," **The American Journal of Occupational Therapy,** IX:5, Part II (September-October), pp. 248-249, 1955.
8. Fidler, Gail S. and Jay W. **Introduction to Psychiatric Occupational Therapy.** New York: Macmillan Co., 1954.
9. Goodrich, D. Wells. "Research in Psychiatric Occupational Therapy," **The American Journal of Occupational Therapy,** VI:1 (January-February), pp. 1-3, 1952.
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12. **Occupational Therapy: Manual of Reference for Personnel,** pp. 1-8. Albany: NYS Department of Mental Hygiene, 1956.
13. Schwarz, Morris S. and Emily L. Shockley. **The Nurse and the Mental Patient, A Study in Interpersonal Relations.** New York: Russell Sage Foundation, 1956.
14. Weinroth, Leonard A. "Dynamic Occupational Therapy," **The American Journal of Occupational Therapy,** IX:5, Part II, (September-October), pp. 243-254, 1955.
15. Wendland, Leonard V. "Psychodynamic Aspects of Occupational Therapy," **The American Journal of Occupational Therapy,** X:4, Part II (July-August), pp. 244-247, 1956.
16. West, Wilma and Henrietta McNary. "An Abstract of a Study of the Present and Potential Role of Occupational Therapy in Rehabilitation," **The American Journal of Occupational Therapy,** X:4, Part I (July-August), p. 150, 1956.
17. Willard, Helen S. and Clare S. Spackman, eds. **Principles of Occupational Therapy,** 2nd ed., pp. 76-116.. Philadelphia: J. B. Lippincott Co., 1954.
18. Wittkower, E. D. and John D. LaTendresse. "Rehabilitation of Chronic Schizophrenics by a New Method of Occupational Therapy," **British Journal of Medical Psychology,** 28: pp. 42-47, 1955.

Unit X: 4 *Hours*

Topic: Working together (group dynamics)

Material Covered

1. Forces operating for and against smooth intradepartmental and interdepartmental functioning.
2. Analyzing problems and conflicts
3. Methods of working toward solution

Suggested Approaches

1. Workshop techniques
2. Re-enactment of structured situations in AJOT, Vol. IX:5, Part II, pp. 211-223; followed by group discussion based on questions used in these articles

References

1. Digest of speeches from the AOTA Institute on Interpersonal Relationships, Washington, D. C. **The American Journal of Occupational Therapy,** IX:5, Part II (September-October), pp. 211-256, 1955.
2. Greenblatt, Milton, R. H. York and E. L .Brown. **From Custodial to Therapeutic Care in Mental Hospitals.** New York: Russell Sage Foundation, 1955.
3. Harrower, Molly, ed. **Medical and Psychological Teamwork in the Care of the Chronically Ill.** Springfield, Ill.: Charles C. Thomas, 1955.
4. Stanton, Alfred H. and M. S. Schwarz. **The Mental Hospital, A Study in Institutional Participation in Psychiatric Illness,** Chapter IV, "Communications," pp. 193-242. New York: Basic Books, Inc., 1954.
5. **Understanding How Groups Work.** Adult Education Assoc., 743 N. Wabash Ave., Chicago, Ill.
6. Wittenberg, Rudolph M. **The Art of Group Discipline.** New York: Association Press, 1951.

Unit XI: 140 *Hours*

Topic: Media

Material Covered

1. Major crafts
2. Minor crafts
3. Recreational and social activities

Suggested Approaches

1. Four-point method of teaching
2. Learning laboratory (relate the thinking and doing aspects of the activity with the feelings which were aroused)

References

1. Willard, Helen S. and Clare S. Spackman, eds. **Principles of Occupational Therapy,** 2nd ed., pp. 175-180. Philadelphia: J. B. Lippincott Co., 1954.
2. The Colorado Occupational Therapy Association. **At Your Fingertips.** Denver: Smith-Brooks Printing Co., 2130 Welton St., rev. 1952.

Unit XII: 160 *Hours*

Topic: Suggested areas of supervised experience

Material Covered

1. Acute service
2. Convalescent service
3. Continued treatment service
4. Special groups, i.e., convulsive therapy, pediatrics, geriatrics, chemotherapy, research, mentally retarded, epileptic.

Suggested Approaches

Under the supervision of the registered occupational therapist (in the clinic, on the ward, or in an activity area).

References

1. **Staff Development, The Supervisor's Job** (training manual no. 6). Washington, D. C.: U. S. Gov. Printing Office, 1954.
2. Supervision and Consultation (**leadership pamphlet no. 7**). Adult Education Assoc., 743 N. Wabash Ave., Chicago, Ill.
3. Whitcomb, Beatrice, Major, AMSC. "Principles of Supervision," **The American Journal of Occupational Therapy,** X:6 (November-December), pp. 288-292, 1956.

Unit XIII: 7 *Hours*

Topic: Evaluation

Material Covered

1. Didactic material
2. Practical application

Suggested Approach

1. Final examination
2. Seminar on evaluation of course at close of program
3. Reports of performance during training
4. Post-training program questionnaire
5. Sample interviews with trainees
6. Hospital reports on back home performance
7. Post-mortem meetings of planning committee

References

1. Beckhard, Richard. **How to Plan and Conduct Workshops and Conferences.** New York: Association Press, 1956.
2. Hook, J. N. **How to Write Better Examinations,** pp. 12-13. New York: Barnes and Noble, 1941.

Audio-Visual Education

(Note: As a teaching aid, the *Opaque Delineascope* is a useful piece of equipment to project the page of a book, charts, or other miscellaneous data, onto a screen.)

Sources of films and filmstrips:

1. "A Directory of 2660 16mm Film Libraries," available for 50 cents from the Government Printing Office, Washington 25, D. C.

2. "Directory of Professional Medical Motion Picture Films and Authors," Professional Publications, Lawrence, Kansas.

3. "Educational Film Guide," H. W. Wilson Company, New York 52, New York.

4. "Films in Psychiatry, Psychology, and Mental Health," Medical Audio-Visual Institute of the Association of American Medical Colleges. Published by Health Educational Council, New York City, 1953. This book contains an elaborate description of 41 films, and 50 additional films with briefer descriptions.

5. "Mental Health Motion Pictures," National Institute of Mental Health, U. S. Public Health Service, Washington 25, D. C.

6. "Motion Pictures on Child Life," Children's Bureau, U. S. Department of Health, Education and Welfare, Washington 25, D. C.

7. "Psychological Cinema Register," Pennsylvania State University, State College, Pa.

8. "Selected Films for Mental Health Education." National Association for Mental Health, New York 16, New York.

9. Shalik, Harold, O.T.R. *Manual of Visual Aids for O.T.* Billerica, Massachusetts: Occupeutics Publications Division, 30 Lindsay Road.

10. Stevenson, George S. *Mental Health Planning for Social Action.* Chapter: Visual Aids, pp. 319-340. New York: McGraw-Hill Book Company, Inc., 1956.

1. American Hospital Association, 18 East Division Street, Chicago 10, Illinois. Write to: Chief, Educational Activities. Catalogue of films, strips and slides will be sent upon request.

2. American Occupational Therapy Association, 250 West 57th Street, New York 19, New York. Mimeographed list of films and slides.

3. CBS-Television, 485 Madison Avenue, New York City, New York. For rental, 27 filmed programs in the series titled, "Search."

4. Film Council of America, 600 Davis Street, Evanston, Illinois. Central film information service.

5. Film Service; local State Department of Mental Health, Bureau of Public Health Information or State Association of Mental Health (affiliation with National Association for Mental Health).

6. International Film Bureau, 57 East Jackson Boulevard, Chicago 4, Illinois.

7. New York University, 26 Washington Place, New York 3, New York. Film Library catalogue.

8. University of Southern California, Box 274, Los Angeles 7, California. Colored slides (32) on occupational therapy training.

Certification procedure forms for occupational therapy assistants may be obtained from the:

Education Office
American Occupational Therapy Association
250 West 57 Street
New York 19, New York.

Dynamic Therapy . . .

(*Continued from page* 244)

particularly in acutely regressed patients. We feel this treatment can be applied to many of the regressed patients in our hospitals.

Patients thus treated establish a better contact with reality and higher ego integration, resulting in better functioning in and out of the hospital. This therapy may be followed by individual and group psychotherapy. Occupational therapy may be carried out in the future with higher levels of object relationship.

These concepts may well be further explored to establish better means for fulfillment of needs and presenting of objects, for ascertaining objects for particular symptoms and optimal timing of presentation. Various types of nourishment may also be tried.

We have attempted by means of a new parent-child-sibling relationship to undo and build anew our patients' emotional development, and as Freud said, "to correct the blunders for which parental education is to blame."

REFERENCES

1. Sechehaye, Marguerite: *A New Psychotherapy in Schizophrenia.* New York: Grune and Stratton, 1956.
2. H. Azima and E. D. Wittkower, "Gratification of Basic Needs in Treatment of Schizophrenics," *Psychiatry,* XIX; pp. 121-129, 1956.

Specialists . . .

(*Continued from page* 254)

employees; places where the person will come to work "between jobs." This strongly affects the attitude of the staff, especially when it comes to changes in routine. If the staff believe that the department head is certain to leave in a short time, they are unlikely to exert themselves in adapting to any changes. One charge nurse told his ward psychiatrist, "Doctor I have seen four clinical directors come and go, and I will see you go too." Needless to say this nurse was not motivated to change the regimen on his ward. The same point applies to OT departments. Besides the hostility an occupational therapist may face from the previous department head whom he displaces, he may also encounter a wall of resistance against any change in operating procedure.

There is a congruence in distrust of "the expert" and fear of "the stranger." Often the specialist may have lived or trained at some distance from the hospital. Those with whom he works may feel that he looks down on them both professionally and socially. In the setting of a small community this may be fatal to the OT who would like to build up a strong volunteer program. Someone without roots in a community will have an extremely difficult task in recruiting part time volunteers.

George Simmel[8] in his remarkable essay, "The Stranger," points out that experts are often deliberately recruited from the outside because of their supposed objectivity. In various Italian cities, judges were always called from some distance because no native was considered free from family ties or party interests. However he also warns that the stranger-expert may easily become a scapegoat for the local inhabitants in times of tension. This has relevance for the situation of the occupational therapist who is brought into a hospital by the clinical director "over the heads" of the local staff. He may find that in times of crisis or staff discontentment, the local staff will turn upon him and perhaps even blame him for their troubles. This would be more likely to occur in an established state hospital in a small community than in a VA hospital which "grew up overnight" (and where most of the staff was recruited from the outside) or in a university-affiliated hospital where the staff is rotated frequently.

REFERENCES

1. Dalton, M. "Conflicts Between Staff and Line Managerial Officers," *Amer. Soc. Rev.*, 15, 342-351, 1950.
2. Dubin, Robert. *Human Relations in Administration.* New Jersey: Prentice-Hall, 1951, p. 113.
3. Merton, R. K. "The Machine, the Worker, and the Engineer," *Science,* 105, 79-81 (Jan. 24), 1947.
4. Stainbrook, E. J. "Human Action in the Social System of the Psychiatric Hospital," in *Better Social Services for Mentally Ill Patients* (Ed. by Ruth Knee). New York: Amer. Assoc. of Psychiat. Soc. Workers, 1955.
5. Laski, H. J. "The Limitations of the Expert," *Harpers Magazine,* 162, 102-106, (Dec.) 1930.
6. Friery, J. F. Symposium recorded in *The Journal of the American Medical Association,* April, page 1257, 1956.
7. Von Mering, O., and King, S. H. *Remotivating The Mental Patient,* New York: Russell Sage Foundation, 1957.
8. Simmel, G. *The Sociology of George Simmel,* Trans by Kurt H. Wolff. Glencoe: Free Press, 1950.

Night Splint . . .

(*Continued from page* 246)

thirty inches long. It has three additional buckles attached at the prong end of the buckles as shown in Figure III. The loop end of one buckle is pushed through hole "d", one through hole "e," and one through hole "f" from the back side. The strap then enters a hole "g"

coming out of the front side of the brace and passes through the protruding buckle loops at "f," "e", and "d." It finally passes through hole "e" and buckles to its opposite end. In this manner the finger strap can be pulled across from finger to finger through these protruding buckle loops quickly with very little binding.

The very long strap is used so that large loops can be made from finger to finger, and positioning of a contracted hand may be accomplished more easily.

SUMMARY

This brace offers a method of making a very light (eight ounce) brace which is cosmetically acceptable with a minimum of metal pieces and provides the maximum amount of comfort. It provides one of the best possibilities for a patient to be able to tolerate a brace while sleeping; it is comfortable to the patient, provides an individual finger, palm and arm sling suspension system, and it affords safety because of the lack of metal parts and because of its light construction.

It has the considerable advantage to the therapist or braceman in that the brace can be ordered and fitted much as you would a pair of gloves or shoes. It can be made easily and quickly after the selection of one of the hand casts initially constructed.

In some special cases, where the hand is too contracted to get into the brace, or stretch is required above the neutral position, the brace can be hinged at the wrist as depicted in Figure IV. The brace can be cut in half at the wrist and a "regular" one-inch flat hinge laminated in. Extension is gained by straps across the back of the hand. The hinge enables the splint to be applied with the wrist in a flexed position which relieves the tension of the finger flexors and thereby enables the splint to be applied to a badly contracted hand. It also allows the fingers and wrist flexors to be extended beyond neutral position when such stretching is indicated.

If you have back issues of the *American Journal of Occupational Therapy* that you would like to make available to the Nebraska Psychiatric Institute Library, please write Mr. H. Dwyer Dundon, O.T.R., Occupational Therapy Department, Nebraska Psychiatric Institute, 602 South 44th Avenue, Omaha, Nebraska. They are seeking a complete file of AJOTS but will appreciate a limited collection of any available copies.

MIDYEAR MEETING OF THE BOARD OF MANAGEMENT

American Occupational Therapy Association
Cosmopolitan Hotel, Denver, Colorado
April 12-13, 1958

Members Present—
Miss Marguerite Abbott
Miss Mary Britton
Miss Ruth Brunyate
Miss Marion Crampton
Miss Jeannine Dennis
Miss Marie Louise Franciscus
Mrs. Margaret Mathiott
Lt. Col. Myra McDaniel
Miss Elizabeth Messick
Miss Frances Miller
Mr. Laurel Nelson
Miss Margery Peple
Miss Mary Reilly
Miss June Sokolov
Miss Florence Stattel
Miss Caroline Thompson
Miss Beatrice Wade
Miss Wilma West

Members Absent—
Dr. William R. Dunton, Jr.
Mrs. Gail Fidler (Proxy: Col. Robinson)
Mrs. Ivabelle B. Rhodes
Sister Jeanne Marie Bonnet (Proxy: Mr. Nelson)
Miss Jacquelin Wright

Ex Officio—
Miss Marjorie Fish
Miss Helen Willard

Auditors—
Miss Irene Hollis
Mrs. Lucie Murphy
Miss Virginia Kilburn

Presiding: Lt. Col. Ruth A. Robinson, President.

Minutes of the previous meeting of the Board of Management, held in Cleveland, October, 1957, were presented for approval. Two corrections were suggested: (1) In the report of the project committee on recognition of OT assistants, addition of Board vote changing status to that of a standing committee. (2) In the report on group for advancement of psychiatry, reading should be ". . . . . appropriate material has been prepared for Dr. Barton, and Board endorsement should be given to support Miss Crampton's representation."

It was voted to accept the minutes of the 1957 annual meeting with the above corrections.

Executive Reports

Report of the treasurer: Miss Wilma West. Appeals for financial contributions have been received from the World Federation of Occupational Therapists and the Joint Commission on Mental Illness and Health.

It was voted that the AOTA contribution to the World Federation of Occupational Therapists be raised to $400 per year for five years.

It was voted that a $100 contribution be made to the Joint Commission on Mental Illness and Health.

The executive committee recommended, and the *Board voted* to increase active membership dues from $10 to $12 ($2.00 increase), and registration fees from $8.00 to $12.00 ($4.00 increase) effective July 1 for the 1958/59 fiscal years.

The treasurer presented several exhibits accompanying the financial report and the proposed budget for 1958/59 including suggested distribution of additional income based on the $6.00 increase in dues and fees. The proposed items provided for both current and new expense accounts: grant to educational fund, salaries, office manager, House of Delegates, travel, committee expenses, annual conference fund, revolving publications, reserve/investment. The Board discussed the proposed tentative allocations for these categories.

The executive committee recommended that the treasurer, speaking for the finance committee, prepare an interpretative detailed explanation of the action to increase membership dues and registration fees in terms of the state vote, for distribution to the membership at an early date. It made the further recommendation that action be delayed on the matter of lowered dues for non-practicing O.T.R.'s until further study is completed by the

committee from the House of Delegates before interpretation to the membership.

It was voted that an interpretive statement be distributed to the membership via two methods: (1) as a total mailing to members and registrants on an individual basis, (2) accompanied by delegates' Newsletter and Board minutes, to state associations.

It was voted the report of the treasurer be accepted with appreciation

Report of the speaker of the House of Delegates: Mrs. Margaret Mathiott. Board comments and opinion were requested by the committee on OT treatment fees. Discussion centered on speed and methodology of conducting such a study, proposed questionnaire, and feasibility of submitting completed report as a suggested form to the joint accreditation commission or the section on professional practices of the American Hospital Association.

It was recommended that the questionnaire, after review by the section on professional practices of the American Hospital Association, be forwarded to all treatment centers except federal hospitals, with a particular request for information on the semantics of hospital classifications.

Board discussed letter of March 21 to all delegates from chairman of the House of Delegates committee to study lowered membership dues for non-practicing O.T.R.'s It was felt that the suggested fee for inactive therapists was too low in terms of the services offered, and that this fee should cover membership only, not registration.

It was voted that the speaker of the House work with the chairman of the committee and the treasurer in composing a letter which would be sent immediately to the delegates to clarify the chairman's letter of March 21, particularly relative to differentiation of membership and registration.

It was voted the report of the speaker be accepted with appreciation.

Report of the editor of AJOT: Mrs. Lucie Murphy. The editor's advance report requested Board opinion on: (1) Draft of a letter for members requesting support of Journal advertisers. (2) Sale of Journal covers. (3) AJOT printing of survey by the special studies committee. (4) Printing of evaluation of 1957 institute-conference.

The editor recommended that the printing of special studies committee survey be given further consideration by the committee, as it is not suitable for printing in AJOT due to difficult mechanics involved and prohibitive cost. The editor recommended that the evaluation of the 1957 conference, which was not compiled with the objective of AJOT publication, not be printed therein.

It was voted that the editor be authorized to send the proposed letter to individual members, and that an approach on the matter be worked out for state associations through the delegates.

It was voted that the AJOT covers should not be made available.

It was agreed that the matter of the special studies survey receive further committee study and recommendations, and that careful thought be given to the editor's suggestions for printing elsewhere.

It was voted the report of the editor be accepted with appreciation.

Report of the director of public information: Miss Julia Hardy. The director reported that the film "OT Story" has circulated in 26 states. Increased recruitment continues to be the greatest need. Efforts are being directed toward several objectives: (1) Greater continuity to recruitment committees. (2) Setting up a new regional plan with chairmen. Recruitment workshops are scheduled to be held in Richmond, Virginia, May 9-11, and Minneapolis in June. (3) Preparation of a booklet with comprehensive scholarship information. (4) Avoiding duplication in supplying literature. A centralized listing to be utilized for mailings would simplify the problem. The NFIP will be approached relative to use of theirs among the four professional groups for whom they finance recruitment programs. (5) Greater professional acceptability by physicians.

It was voted that the report be accepted with thanks.

Report of the field consultant in rehabilitation: Miss Irene Hollis. Advance report to the Board was reviewed by the field consultant, indicating the brief three-month period since the position was established. Channels of announcement to members and related groups were outlined as well as the coverage thus far accomplished through meetings attended, speaking engagements and institutions visited. Mention was made of the scarcity of requests for consultancy received as yet. Board members were requested to take responsibility for publicizing the availability of this new service.

This report was accepted with thanks.

Report of the executive director: Miss Marjorie Fish. Reported for Board action were recommendations from the report of the associate director, Miss Helen Mathias.

1. *It was voted* to authorize the sale of the Yearbook to prospective advertisers at cost.

2. *It was voted* that the $10 fee for enclosure of material with the Newsletter should be raised, the amount to be determined by the national office in accordance with the nature of the enclosure material, but with a minimum charge of $25.00.

3. *It was voted* that the brochure, "AOTA Administrative Practices and Personnel Policies" be reprinted, deleting the salary ranges within the content, but adding a separate flyer or sheet with this information for those who request it, to be reviewed and changed periodically as indicated.

The Board members received copies of the executive director's report which was presented in outline form and dealt with: membership and registrant statistics; field program coverage by national office staff; publications under auspices of the Association, newly completed, pending completion, in revision; status of grants (requests submitted, currently operating, terminating) totaling approximately $219.000; international issues relative to policies on foreign visitor exchange, handling of foreign visitations, and recipients of AOTA membership under the International Cooperation Administration.

It was agreed that the president or executive committee would set up a structure to handle the selection of recipients of ICA membership and to assist in international issues. (See these minutes for action under World Federation of Occupational Therapists.)

The Board endorsed the sending of a statement of interest on behalf of the AOTA in the 8th world congress of the International Society for the Welfare of Cripples, to be held in New York City, 1960.

It was voted the report of the executive director be accepted with appreciation.

Report of the education office: Miss Mary Frances Heermans. The report from the education office, summarizing events of the past four years, was sent in advance to Board members. It was also sent to all members of the education committees, in order to save time in committee. This procedure will be followed henceforth. The report included no items on which Board action was required.

The Board expressed appreciation for Miss Heerman's valuable contributions during her tenure as director of the education office, and welcomed her successor.

The report was accepted as representing an outstanding accomplishment.

Report of the council on education: Miss Caroline Thompson. Council action reported: (1) a vote to revise its membership to include persons who regularly serve as AOTA members on the AMA advisory committee on OT education. (2) A vote to appoint a committee (including representation from all the education committees) to study committee operation with particular reference to the program of the midyear meeting. (3) Discussion concerning a letter received from an institution desiring to initiate a master's degree program in health studies (with no undergraduate program established. (4) Interpretation of AMA *Essentials*, and the possibility of securing authorization for reasonable flexibility.

The council reported that a committee has been appointed to work on the problems of the various levels of an educational program, and the degrees to be granted in accordance with determined qualifications. A report will be rendered at the annual meeting.

The Board voted that the council on education revise its membership to include persons who regularly serve as AOTA members on the AMA advisory committee on OT education.

It was voted that a study be made of midyear meeting program operation to increase efficiency of time and contribute greater professional value.

It was voted that a letter be sent from the AOTA council on education to the council on medical education and hospitals of the AMA, asking the latter to give us a statement reaffirming the principle of reasonable flexibility in interpreting the AMA *Essentials* during the interval period until basic changes are made.

It was voted the report be accepted with thanks.

Reports of Chairmen of Special Committees

Committee on OT reference manual for physicians: Miss Marguerite Abbott. The chairman reported the total first draft of the manual will be completed within a few weeks and will proceed forward to committee for second draft preparation.

It was voted the report be accepted with appreciation.

Committee on national office personnel policies: Miss Helen Willard (for Miss Ethel Huebner). Miss Willard presented recommendations made by the executive committee to the Board. These were based on the midyear report prepared by the members of the personnel policies subcommittee relative to the statement of appeal received earlier from the secretarial/clerical staff of the national office dealing with certain items on which they asked further consideration and reevaluation in the new personnel policies.

The recommendations of the executive committee were as follows:

1. New personnel policies to become effective July 1, 1958, with the 35-hour work week.
2. Saturday office hours to be discontinued except in emergency, and then compensatory time allowed.
3. No alterations in daily summer hours during 1958. Recommendation to the personnel policies subcommittee that this be given consideration for the future.

The Board voted to accept these recommendations of the executive committee.

The Board voted that two representatives from the secretarial/clerical staff, rather than one as suggested by the executive committee, be appointed by that group, to sit with the personnel policies subcommittee when indicated in the interest of better understanding and clearer interpretation.

It was voted the report be accepted with appreciation.

Report of the development advisory committee: Miss Wilma West. The committee was charged with implementing distribution of the development plan to the membership, which will be done via documentary dramatic presentation at the 1958 conference, and a booklet subsequently. It is anticipated the documentary will be in partial draft form by May, and professional assistance will be utilized. The Board touched on the matter of a title for the documentary, to be based possibly on ideas from various entertainment media.

No Board action was required at this time.

It was voted the report be accepted with appreciation.

Reports of Chairmen of Standing Committees

Report of permanent conference chairman: Mrs. Winifred Kahmann. The chairman requested Board consideration re conference fees to members of allied professions.

It was voted that the daily conference rate for allied professions be changed from $5.00 to $3.00.

A correction was indicated on Page 4 of the report of the 1958 local conference committee, i.e., "daily rate for non-registered members" should be changed to "daily rate for registered non-members."

It was voted to waive conference fees for those persons serving on conference committees whose duties at the time of the conference prevent their attendance at a majority of the sessions. Decisions on these to be predetermined by appropriate authorities.

Board discussion was directed toward the problem of the reimbursement of expenses for conference committee members.

It was voted that this problem be given study by the permanent conference chairman, local chairmen from the last three conferences, and the chairman of the area currently involved with national office representation, and that a long-range policy be developed to handle the entire matter; it was further voted that the national association match local funds on a 50-50 basis, as interval action, for expenses involved in the 1958 conference planning. This sum is to cover travel expenses (not meals) to meeting places, and arrangements for male and female accommodations (such arrangements to be part of the contract for conferences).

Future conferences: 1959, Chicago. 1960, Los Angeles. 1961 invitations have been received from St. Louis and Detroit, and a decision will be made by the time of the 1958 annual meeting.

It was voted the report be accepted with appreciation.

Report of the clinical procedures committee: Lt. Col. Myra McDaniel. The third printing of *Objectives and Functions of OT* will be available in the near future, and will include all material prepared to date with the exception of the section on cerebral palsy and a TB study by the TB subcommittee (latter is available on loan from the national office).

The committee recommended a national committee on civil defense be established, of standing committee category.

It was voted to commend the chairman, and to accept the recommendation and the report in its entirety. It was suggested that this new committee include some army reserve personnel.

Report of the legislation and civil service committee: Mr. Laurel Nelson (for Miss Virginia Caskey). The model class specifications, approved by the Board at the 1957 annual meeting will be published in the March-April, 1959, issue of AJOT. Board opinion was requested re committee suggestion that the report of salary schedules be tabulated and codified.

It was voted to accept the report of the committee including the request for the coding of salaries, and recom-

mended that a small committee continue studying this subject after meeting with the chairman.

Board suggestions to the committee included the definition of grades, supplying simple terminology for the states to use, and the availability of a listing of all salaries in all states as reference sources.

Report accepted with thanks.

Report of the registration committee: Miss Mary Frances Heermans. A copy of the report was received by all Board members.

No Board action required on the report.

It was voted that the report be accepted.

Report of the recruitment and publicity committee: Mrs. Frances Shuff. The material in the advance report to the Board was covered by the director of public information, hence no personal report was rendered by the chairman.

It was voted that the report be recognized with appreciation.

Report of the committee on recognitions: Miss Florence Stattel. Board consideration was requested for inscription to be placed on gold disks to be awarded to past presidents, and the time of presentation. Ensuing discussion centered on the specific persons to receive the award.

It was voted to award the gold disks to all living past presidents, and to make the wording of the inscription the responsibility of the committee. Details of time and place of presentation will be settled at the 1958 conference.

Report accepted with thanks.

Report of the special studies committee: Miss Marjorie Fish (for Miss Muriel Zimmerman). A copy of the report was received by all Board members.

It was voted to accept the report with thanks, and to give further consideration to adding to the compilation of the special studies survey to make it more complete.

It was voted that the committee be commended for the excellent effort made.

Report of the committee on recognition of the OT assistant: Miss Marion Crampton. No advance report was submitted because the material is still in process of being printed. It will be ready for distribution shortly.

Other Business

Interdisciplinary study group: Col. Ruth A. Robinson. A listing is now available of the participating organizations and their publications. "Communications" has been chosen as the subject on which the group will build future activities, and Board comment is sought with regard to setting up a working group to study this subject. Dr. Donald M. Carmichael has been appointed as official representative to the group from the American Psychiatric Association.

It was Board opinion that a communications survey by the interdisciplinary study group would be helpful and that a small committee should determine the needs in OT. Two years was the time projected as required for completion of this task.

It was voted that a working group be appointed to facilitate this project as rapidly as possible.

It was called to the attention of the Board that occupational therapy is not included in a study of 7000 patients, sponsored by the University of California, to study the kinds of personnel structures which should exist in federal and state hospitals, and it was felt that a letter should be sent to the University about remedying this omission.

It was recommended that Miss Mary Reilly be asked to draft a letter to the University of California which could be reproduced and sent from the national office.

Conference on recreation for the mentally ill: Miss Beatrice Wade. Miss Wade represented AOTA at this November meeting and submitted a written report available to Board members.

Princeton institute, American Psychological Association: Miss Marie L. Franciscus. Miss Franciscus represented OT by individual invitation from APA. This institute, on the subject of "The Role of Psychology and Psychologists in Rehabilitation" was attended by representatives of many fields including occupational and physical therapy, medical social work, speech and audiology, psychiatry, rehabilitation counseling, special education, physical medicine and nursing. The role and contributions of psychology were examined, as were also the necessary background information, educational programming, and its place in rehabilitation and research. Findings at the end of the conference were not conclusive, but it was felt it might serve as a stepping stone to further conferences. A written summary of a questionnaire tabulation is available upon request.

World Federation of Occupational Therapists: Miss Helen Willard. The president announced the U. S. delegates for the next term, 1958-63. The following appointments have been made: delegate, Miss Marie Louise Franciscus; first alternate, Miss Helen Willard; second alternate, Miss Marjorie Fish. The following points were cited as requiring Board action: (1) Appointment of a committee to work with delegates and alternates to help develop increased interest and membership, and in the numerous matters of international scope facing the Association as delineated in the report of the executive director. (2) Consideration of the cost of shipment of exhibits. (3) Changes in the constitutions as set forth in the 1956 WFOT council minutes, and now referred to member countries for approval.

It was voted that the Board accept the report, with the understanding that the newly appointed committee will include within its responsibilities those items discussed earlier.

Report on transfer of AOTA national office to Chicago: Miss Mary Britton. At the 1957 annual meeting it was proposed that a listing of advantages and disadvantages be prepared with regard to moving the national office to Chicago with quarters in the new building of the American Hospital Association. Following careful study of this matter, in the opinion of the executive committee, the listing of disadvantages considerably outweighed the advantages, and it was recommended to the Board that they disapprove the move, and that the membership be informed of this recommendation either through the House of Delegates, or other appropriate method.

It was voted to accept the recommendation of the executive committee that it would not be advantageous at this time to re-locate the national office.

It was voted that this action be communicated through normal channels to the membership, requesting a response for discussion at the time of the 1958 annual meeting, the communication to include an informative statement with reason for the action.

Correspondence

A letter was received from Mr. W. Gorthy, Institute for the Crippled and Disabled, relative to a training program for advisers of pre-vocational evaluation units which the Institute has initiated, and is now seeking AOTA endorsement for an expanded program of such training courses for practicing OT's and directors of OT schools. Board thinking indicated *endorsement* of the concept of professional training in a rehabilitation center as being too strong a term, but it was felt that the *interest* of the AOTA should be expressed.

It was agreed that a letter of reply be sent to Mr.

Gorthy indicating that their concept has merit, and we would be pleased to make the information available to AOTA members.

1959 *Midyear Meeting*

It was voted to hold the 1959 midyear meeting next April in Indianapolis, in response to an invitation from that area.

The meeting adjourned at 6:00 P.M.

Respectfully submitted,

Marjorie Fish, O.T.R.
Executive Director.

DELEGATES DIVISION

GEORGIA

Mrs. Judy Stiles, retiring chairman of the recruitment committee, was able to bring helpful information to the membership from the national conference in Cleveland last fall. As a result of her report renewed efforts are being made in this direction. As we approach our new year, we look to Miss Liss, the new chairman, for even more specific guidance as a result of her participation in the recruitment workshop in Richmond last May. The membership has been able to assist Miss Liss with some of the expenses of this meeting.

Capt. Edna Gleim and her associates in Augusta have once more worked diligently on a revision of the constitution. This final draft brought our constitution into comparable form with that of the national association.

The delegate to the House of Delegates presented the state association with the project of investigating means of offering, through the American Occupational Therapy Association, group malpractice insurance for such members as would desire this protection. Miss Mae Hightower directed this project until she left the state early this year. The project was divided into three tasks. Groups in Augusta, Dublin, and Warm Springs each undertook a specific task. The results of the investigation will be combined in a report to the House of Delegates. It is hoped that a preliminary report will be ready for circulation prior to the annual meeting of the House of Delegates.

Four regular meetings and one special meeting were held during the year. The special meeting was held immediately following the annual meeting of AOTA for presentation of reports on the conference. Miss Mae Hightower showed the slides illustrating the treasurer's report.

We were fortunate in being able to combine a meeting in October with the annual meeting of the Georgia Society for Crippled Children and Adults. We are indebted to Miss Mary Webb, executive director of that society, for providing a meeting of special interest to the physical and occupational therapists of the state. Mr. John Steensma was brought as guest speaker and demonstrator to instruct us in the use of upper extremity prostheses. Miss Patricia Kelsey, O.T.R., gave an excellent presentation of the occupational therapist's role in this area of practice.

The last meeting of the year was a combined meeting with the physical therapists. The topic of the meeting was prevocational evaluation. A panel presentation was followed by a buzz session and a question period. Mr. Raymond Snead, D.V.R. counselor, and Mr. W. W. Key, personnel manager from Lockheed, formed the panel with Miss Nancy Whitney, R.P.T., and Miss Muriel Driver, O.T.R.

OFFICERS

President	Muriel Driver, O.T.R.
Vice-President	Carolyn Mericle, O.T.R.
Delegate	Mary Pat Liss, O.T.R.
Alternate Delegate	Barbara Grant, O.T.R.
Secretary-Treasurer	Cecelie Bearup, O.T.R.
Secretary-Treasurer Elect	Jeannette Martin, O.T.R.

VIRGINIA

Delegate-Reporter, Margery C. Peple, O.T.R.

The Virginia Occupational Therapy Association has held five meetings during 1957-58. The most stimulating for us was a tri-state meeting held at De Witt Army Hospital, Fort Belvoir, Va., at which Miss Muriel Zimmerman lectured on and demonstrated "Splinting, Bracing and Self Help Devices." This was followed by movies and a workshop on making such devices.

"Current Concepts of Amputee Rehabilitation," was the topic of our annual OT-PT meeting held at the Medical College of Virginia Hospital. Dr. Fred Vultee, of the department of physical medicine and rehabilitation, was the principal speaker.

A third program meeting was held at the University of Virginia Hospital, Charlottesville, Virginia. Dr. Donald Rathbun, Jr., spoke on "The Total Approach to the Patient," after which we toured the new Children's Rehabilitation Center.

Virginia acted as hosts to the first regional recruitment workshop. Representatives from thirteen eastern states attended the two-day meeting. This stimulated the local newspaper to run a well presented three-day article entitled "The Use of Occupational Therapy in the Rehabilitation of the Disabled Person."

Our scholarship fund became a reality with the awarding of three scholarships totaling $300 to qualified students attending Richmond Professional Institute.

OFFICERS

President	Marguerite M. Arledge, O.T.R.
Vice-President	Eleanor V. Wolfe, O.T.R.
Recording Secretary	Mary F. Warrington, O.T.R.
Corresponding Secretary	Barbara I. Smith, O.T.R.
Treasurer	Mary E. Blayney, O.T.R.
Delegate	Margery C. Peple, O.T.R.
Alternate Delegate	Donald E. Hines, O.T.R.

TENNESSEE

Delegate-Reporter, Barbara Wallin, O.T.R.

The Tennessee Occupational Therapy Association continues to have two main problems with which to cope: relatively few therapists in the state and those scattered across a wide area. There are too few members in any one area to form a district and due to the prohibitive traveling distances statewide meetings must be limited to two each year. Quarterly newsletters help somewhat to inform others of pertinent happenings but they can hardly take the place of organized meetings.

A week-end meeting in Knoxville has been planned for this fall to combine a stimulating business and program meeting with a pleasure trip to the Smokies. It is hoped that this will prove an incentive for all the members to attend.

Plans are being formulated to enlarge our scholarship fund which is now composed solely of proceeds from sales of our occupational therapy plastic key chains. (These may still be purchased from the Association for fifty cents.)

Our recruitment committee during the past year spoke to numerous student groups in both high school and college levels. Other members in Memphis helped edit a brochure on health careers and participated in a television

health series. Eastern State Hospital in Knoxville exhibited the work of the occupational therapy department at the Tennessee Valley agricultural and industrial fair last fall and plans to do so again in September.

OFFICERS

President ..... Mary Melcher, O.T.R.
Vice-President ..... Phyllis Kramer, O.T.R.
Secretary ..... Doris Hartman, O.T.R.
Treasurer ..... Barbara Goettman, O.T.R.
Delegate ..... Barbara Wallin, O.T.R.
Alternate Delegate ..... Charlotte Staub, O.T.R.

WESTERN PENNSYLVANIA

Delegate-Reporter, Elizabeth Whitaker, O.T.R.

The Western Pennsylvania Occupational Therapy Association has had a gratifying year. An overt effort has been made to improve communications with allied professions while continuing our close communication with local members.

We had the pleasure of having a western visitor at a winter meeting. While in this area demonstrating at two hospitals, Margaret Rood spoke at our bi-monthly meeting. At our invitation, speech therapists and physical therapists attended. This was our first attempt at entertaining allied groups and from comments and reactions proved worthwhile.

At another meeting, a recent arrival to our shores was able to appraise us of the state of occupational therapy in England. In addition her talk stimulated an interest in attendance at the World Federation Congress in Copenhagen and the study tour in London.

Our publicity and recruitment chairman has been busy having approached the local educational television station for possible showing of the recruitment film as well as introducing it to our local group. Other members have recruited at career conferences and high schools. In addition, local physical therapists have distributed some literature.

Next year we look forward to even greater improvement in communication stimulated by the national conference theme.

OFFICERS

President ..... Marjorie E. Roth, O.T.R.
Vice-President ..... Leonora A. Pezzuti, O.T.R.
Secretary ..... Theodora Smolinski, O.T.R.
Treasurer ..... Betsy Jean Fraser, O.T.R.
Delegate ..... Elizabeth W. Whitaker, O.T.R.

Letters to the Editor

To the Editor:

It has been very stimulating to read the recent article, "The Prescription: an Anachronistic Procedure in Psychiatric Occupational Therapy" by June Mazer, O.T.R., and Wells Goodrich, M.D., in the July-August, 1958, issue of the Journal.

My experiences as an occupational therapist in a state hospital have led me to question the value of the static prescription card for a long time. This article has been very helpful in not only analyzing the defects of our prescription philosophy but also in suggesting a new and constructive approach to our problem.

Some therapists in the state system, with whom I have spoken, take issue with the idea of discarding the prescription card. Their argument runs something like this. "State hospitals are in the predicament of handling large numbers of patients with limited personnel including both psychiatrists and occupational therapists. Personal, verbal contacts between psychiatrists and occupational therapists are limited. The plan suggested in the article is more applicable to smaller institutions. In the state we had better hold on to our prescription card contact or we may discover ourselves functioning without adequate guidance from the psychiatrist."

My own rebuttal to this argument would be that prescription card contacts are not adequate anyway. We may need to exert all our efforts in some radically new approach such as suggested by Mazer and Goodrich if we ever hope to gain a satisfying solution. We may be like the neurotic who hates to give up his old ways even though they are unsatisfactory for fear of being left desolate in unknown territory.

As a first step, perhaps a given hospital, interested in trying this approach, could order reprints of this paper. This could be the basis of discussion within the occupational therapy department itself. Then reprints could be distributed to the psychiatrists and an administrative staff meeting devoted to discussion. In this manner the sentiments of the physicians could be determined before the prescription card approach was dropped.

In conclusion I think many occupational therapists in psychiatry including myself are grateful to critics of our present methods. They are friends in disguise for they stimulate us to clearer thinking and continued professional growth.

—Edward Dunning, O.T.R.

Reviews

APPLIED MUSCLE ACTION AND CO-ORDINATION. Kathleen I. McMurrich. Toronto, Canada: University of Toronto Press, 1957, 92 pp.

The object of this book is to explain basic muscle action and coordination to occupational therapy students so specific techniques for restoration of function can be employed.

Muscles of the upper and lower extremities, and the trunk are discussed in regard to their specific and combined actions, their surface anatomy, pathology and crafts that can be employed for specific muscle action. The presentations of actions and pathology are worthwhile, since these topics are concerned with specific function as well as their relationships with other muscles. Only lesions of the median and ulnar nerves were taken up. The book might prove more valuable to students if all the nerves were covered since a thorough knowledge of innervation is important to muscle action and coordination.

Used with other reference materials this book should aid both the therapist and student.

—Lester M. Brower, O.T.R., R.P.T.

TEN MILLION AND ONE; NEUROLOGICAL DISABILITY AS A NATIONAL PROBLEM. Arden House Conference sponsored by the National Health Council. New York: Paul B. Hoeber, Inc. Medical Book Department of Harper and Brothers, 1957, 102 pp., $3.50.

Group discussions from the Arden House Conference held in December, 1955, at Harriman, New York, are summarized in this book. The purpose of the conference was to outline the present status and the future outlook of all the neurological disorders. Discussions centered around the total cost of neurological disorders from an individual basis up through the national level, professional and technical management of these disabilities, problems related to information and education, problems

and preparation of the disabled related to mature living from preschool through old age, and research. Recommendations to the National Health Council on behalf of the "Ten Million and One" persons afflicted with neurological disorders are found in this book. A representative list of the more than 300 neurological disorders, identification of conference participants, and the agencies concerned with neurological disorders are found in the appendices.

—Lester M. Brower, O.T.R., R.P.T.

WORK SIMPLIFICATION. Gerald Nadler. New York: McGraw-Hill Book Company, Inc., 1957, 292 pp., $6.50.

This book gives some approaches for simplifying complex work activities in order to eliminate unnecessary work, arrange remaining work in the best possible order, and to make certain that the right method is used. Work simplification, (or motion study or methods study) gives aids to enable one to look at work and see what it involves.

An occupational therapist doing administrative work can benefit from the section that gives information on the Form Process Chart when planning the design and sequence for future systems, procedures and forms.

Those therapists concerned with the method of analyzing work sequence for patients in a sheltered workshop would find the book of value.

The charts, diagrams and explanations are pertinent and clearly done. The chapter on the Therblig Chart is of interest in the basic breakdown of activity that is given in regard to time. The word "therblig" was originated by Frank and Lillian Gilbreth. The name of the chart refers to the symbols used. The symbol, a written explanation, and a photograph is shown of forty-eight work classifications such as pinch grasps right through the movement of the body, with the knees as a hinge.

The bibliography lists pertinent motion-pictures, bulletins, periodicals, and special reports as well as books.

—Eunice Ford, O.T.R.

DIRECTORY FOR EXCEPTIONAL CHILDREN. Boston: Porter Sargent, 1958, 320 pp., $6.00.

A directory of educational facilities in day or boarding schools for the emotionally disturbed, the orthopedically handicapped, the mentally retarded, the blind and partially sighted, the deaf and hard of hearing, and children with speech impairment.

The directory is arranged according to geographic areas rather than listing the states alphabetically which aids greatly in looking for facilities within a reasonable travel area.

NEW KEY TO WEAVING. Mary E. Black. Milwaukee: Bruce Publishing Co., 1957, 571 pp., $12.00.

A comprehensive volume on weaving which serves as an excellent textbook. A complete revision and enlargement of Miss Black's *Key to Weaving*, it includes more information about variations of some of the weaves and how to devise patterns and variations.

HOSPITAL ACCREDITATION REFERENCES. Chicago: American Hospital Association, 1957, 136 pp., $3.25.

A comprehensive reference for anyone seeking specific information about the hospital accreditation program. The material is well presented and compiled for easy reference.

HOW TO WRITE SCIENTIFIC AND TECHNICAL PAPERS. Sam F. Trelease. Baltimore: Williams and Wilkins Co., 1958, 176 pp., $3.25.

The material is presented in a terse, factual style and contains some details about preparing scientific manuscripts seldom found in books of this size.

GUIDE TO CAREER INFORMATION. New York Life Insurance Company. New York: Harper & Bros., 1957, 203 pp., $3.00.

An annotated bibliography of recent, professionally-approved occupational literature that should prove of great value to students interested in finding out about jobs and to parents and vocational counselors advising young people about a career.

The New York Life Insurance Company has made a valuable contribution to the continuous problem of recruitment.

SELF-HELP DEVICES FOR REHABILITATION. A co-operative service project made possible by The National Foundation for Infantile Paralysis and conducted by New York University-Bellevue Medical Center, Institute of Physical Medicine and Rehabilitation. Dubuque, Iowa: Wm. C. Brown Company, 1958, 418 pp., $4.75.

This volume is the compilation of eight monographs already published by the Institute of Physical Medicine and Rehabilitation of the New York University-Bellevue Medical Center. Under a grant from the National Foundation for Infantile Paralysis, the Institute has been engaged in studying devices for the handicapped for the purpose of disseminating knowledge to hospitals, physicians and patients. The study, conducted by research in medical libraries, letters to hospitals, clinics, rehabilitation centers, the U. S. Patent Office, shops, mail order catalogues, suggestions of patients and through the co-operation of physicians and private patients is still being continued.

The pages are loose leafed so new items can be added, and the present order can be rearranged. Over 400 self-help devices are pictured. The source, cost, description, purpose, and use of each item is listed. The accessibility of having information on all these self-help devices located under one cover is an important advantage to the handicapped seeking independence, efficiency, and comfort.

—Lester M. Brower, M.A., O.T.R., R.P.T.

PSYCHOANALYTIC CONTRIBUTIONS TO PSYCHOSOMATIC RESEARCH. Louis Linn, M.D., *Psychosomatic Medicine*, 20:2 (Mar-Apr) 1958.

The object of this presentation is to define those areas of psychosomatic research to which psychoanalysis has made contributions, and to indicate the way in which this has been accomplished.

The concept of the unconscious mental processes as experimental variables is the chief contribution of psychoanalysis to psychosomatic research. The combined factors of repressed infantile wishes and fears and the mechanisms of defense exert a molding influence on every conscious thought and action, and often play the predominant role in the overall clinical picture. Consideration of the unconscious mental processes of the experimenter introduces a new dimension into the problem of experimental design in psychosomatic research. The experimenter is commonly regarded as an objective observer. Conscious and unconscious emotional investments in a given project exert subtle but critical influences in the way a scientist structures his experiment, what observations he emphasizes, and what he chooses to disregard, as is shown by the analysis of several experimenters.

Techniques for exploring the unconscious, such as free association, projective tests, symptom response, and occupational therapy, are of considerable value in psychosomatic research. Psychoanalysis began with the study of psychological aspects of physical symptoms and provides a theoretical frame of reference for psychosomatic research.

—Marilyn S. Trainer, 1/Lt., AMSC.

REHABILITATION OF THE CARDIAC PATIENT. Herman K. Hellerstein, M.D., and Amasa B. Ford, M.D. *The Journal of the American Medical Association*, 164:3 (May 18) 1957.

This article reports a plan for the rehabilitation of patients with heart disease, from initial illness through convalescence to return to work. The physician is pointed out as the comprehensive guide in the course of treatment, employing and integrating the many contributing services: medical, psychiatric, vocational, social, occupational therapy, and physical therapy.

This report states that for approximately 80 per cent of cardiac patients the private physician can manage the total rehabilitation. It is for the 20 per cent remaining that the benefit of the specialities is required in the team approach, or the so-called "multidiscipline approach," herein presented.

The nature and course of heart disease is discussed, with management of the disease at onset, during the acute phase, and after the crisis. It is during hospital convalescence that the various team disciplines are put into action, with a balance of rest and graded activity. Emotional reaction to physical disability must be given full consideration.

Much of the information presented here is gained from six years experience in the Cleveland Work Classification Clinic, with 1100 patients. The authors find from follow-up studies on the selective placement of cardiac patients in industry that there have been no medico-legal compensation cases involved, and no evidence that employment has aggravated the underlying disease in cardiac patients.

—Dorothy R. Street, Lt., AMSC.

ELECTROMECHANICAL ARM SLINGS. Earl F. Hoerner, M.D., Beverly Konugres, O.T.R., and Donald Smith. *The Journal of the American Medical Association*, 165:2 (September 14) 1957.

The authors report the use of a mechanical device—electromechanical arm slings—designed to place the upper extremities through a range of functional positions to further independent living for the physically handicapped. These slings are separately operated and controlled by means of a switch powered by a 12-volt battery motor, requiring a maximum pressure of less than a quarter pound. This pressure may be exerted by shoulder shrug, neck flexion or extension, finger or toe flexion, or by leg movement. Reportedly this makes the sling practical for various types and degree of muscle-power involvement, and as a composite unit this device is attachable to any standard wheelchair or table without additional apparatus.

For disabled persons who have functional hands but loss of muscle power in shoulder, arm, or forearm, by proper support and positioning, these slings permit increased range of motion for bi-lateral activities, aid in performance of daily living activities, and broaden the scope of occupational pursuits.

The construction of this electromechanical apparatus is set forth in detail, and a case study of its use is reported in this article.

—D. R. Street, Lt., AMSC.

THE ROLE OF PHYSICAL MEDICINE AND REHABILITATION IN RHEUMATIC HEART DISEASE. Louis B. Newman, M.D. *The Journal of the American Medical Association*, 165:12 (November 23) 1957.

This research article deals with the total rehabilitation of those with rheumatic heart disease, reviewing incidence, pathology, clinical manifestations, and prognosis.

Success in physical medicine and rehabilitation for those with rheumatic heart disease is seen as obtainable only when activities are completely coordinated with the larger clinical program. Not only must the immediate needs of the patient during hospitalization be cared for, but the future needs of the post-hospital period must be anticipated. This later adjustment becomes a matter of matching physical and mental capacities of the patient with requirements of his or her job.

There must be "no routines" in this rehabilitation program. The degree of "activity restriction" must depend upon the activity or quiescence of the rheumatic process of the individual patient at any given time, and correlated with his general condition as evidenced in energy consumption during activity.

Participation in a progressive activity program affords the medical staff a tangible assessment of the individual's ability and work tolerance, while revealing to the patient and to his family a realistic awareness of his abilities and limitations. Vocational counseling and selective job placement have been found advisable in the early stages of rehabilitation at hospital or center. In the case of child patients, emphasis should be on continuance of a normal education program.

The concept of total rehabilitation procedures in the management of rheumatic heart disease is vital to the accomplishment of a realistic productive life goal for the individual patient, and is economically sound for society. It is concluded that all available resources—county, state and federal—should be called upon to this end, and that continued research in the fields of preventive medicine, infectious diseases and heart surgery is highly desirable.

—D. R. Street, 1st Lt., AMSC.

ELECTROMYOGRAPHY AND ELECTRIC STIMULATION OF NERVES IN DISEASES OF MOTOR UNIT. Lee M. Eaton, M.D., and Edward Lambert, M.D. *The Journal of the American Medical Association*, 163.13 (March 30) 1957.

An appraisal of the clinical value of electromyography and electric stimulation of nerves and muscles, in diseases affecting the motor unit (neuromuscular disease) is preceded in this article by a review of the electrophysiology of muscle contraction and of the technique of electromyographic testing.

Observation of variations of electric potential detected by a needle electrode inserted into skeletal muscle is made under three conditions, as follow: (1) on insertion or movement of the needle electrode, (2) while the muscle is relaxed at rest, (3) while the muscle is voluntarily contracted. This electric activity or potential is recorded on a cathode-ray oscilloscope and played over a loud-speaker system for simultaneous visual and auditory analysis.

The motor-unit action potentials resulting from voluntary contraction vary in characteristics of amplitude, duration and shape, number, rhythm and rate of firing relative to the strength of contraction, dependent on whether the muscle and innervation is normal or abnormal. Differential diagnosis may be made on this

basis, even when the clinical picture is similar. An example of differences in motor-unit action potentials in disease of the lower motor neuron cells and in primary muscle disease is cited. Cases of carpal tunnel syndrome diagnosed by data gained from electromyography are shown to be confirmed by electrical stimulation studies.

The usefulness of electromyography in clinical research as well as in the solution of practical problems is discussed by the authors. At present the value of electromyography and related techniques is felt to be not in the frequency of use but in the quality of information supplied in selected cases.

—D. R. Street, 1st Lt., AMCS.

GROUP THERAPY PROGRAM FOR CHRONICALLY UNEMPLOYED PATIENTS. R. M. Mick and R. W. Heine. *Psychological Reports*, 3:607, 1957.

A study of seven chronically unemployed psychiatric outpatients who were exposed to simulated work experiences in the occupational therapy section. The program then became a primary focus of discussion in group therapy meetings.

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POSITIONS AVAILABLE

Wanted: a trained or registered occupational therapist to assume supervision of entire OT-RT program in small private psychiatric hospital. Salary open. Contact Medical Director, Carrier Clinic, Belle Mead, N. J.

Registered occupational therapist (female) to develop and head new department in 192-bed geriatric institution. New OT facilities to be included in new building to be constructed in 1959. Three weeks paid vacation, sick leave, holidays, 5-day week, meals. Salary $4800 to $5400. Position open October 1st. Write: Administrator, River Bluff Nursing Home, N. Main Road, Rockford, Illinois.

Registered occupational therapist to develop and maintain program for new 100 bed psychiatric unit in large midwest hospital. Salary open. A wonderful opportunity for the right person. Address Box 25, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee, Wis.

Wanted: OTR, female with psychiatric experience. To assume responsibility, after a period of indoctrination, for 45-bed private unit. Benefits—board/room, Blue Cross, sick leave, social security, insurance policy after one year, other standard benefits. Salary open. Elmcrest Manor, 25 Marlborough St., Portland, Conn.

Position open, Saint Albans Psychiatric Hospital, Radford, Virginia. Recreation and occupational therapy director for 120 bed private psychiatric hospital located in southwest Virginia. Prefer young woman who has completed training—interested in a challenging situation. Wonderful opportunity for growth. Address inquiries: Don Phillips, Administrator, Box 1172, Radford, Virginia.

Occupational therapist in private psychiatric hospital (O.T.R.). Work includes recreation and entertainment as well as the occupational therapy program for both women and men. Maintenance is provided. Salary open. Apply to Clifford D. Moore, M.D., Medical Director, Stamford Hall, Stamford, Connecticut.

Supervising occupational therapist for outpatient rehabilitation center. Caseload primarily chronically ill or pre-vocational. Salary range $4600-$6300. 35 hour week. Position available in September. Write Gerald E. Cubelli, Executive Director, Mobility, 427 Main Street, New Rochelle, New York.

Occupational therapist to take full charge of an active department in a 350 bed general teaching hospital and to be in charge of occupational therapy students from an affiliated school. 44 hour week, one month's vacation plus other liberal personnel benefits. Salary $4,600 per year. Write Mr. Edwin L. Taylor, Director, The Graduate Hospital, Philadelphia 46, Pa.

Occupational therapist for Cerebral Palsy Treatment Center. Fully equipped. Good working conditions. Excellent salary. Scholarship funds available for additional training. Write Herman L. Rudolph, M.D., 400 North Fifth Street, Reading, Pennsylvania.

Occupational therapist to establish occupational therapy section of new children's rehabilitation center. Entire center and operation new. Occupational therapy center equal status with other co-medical sections. Persons applying must be qualified and willing to assume chief rating in year or so. Salary open and commensurate with qualifications. Refer replies to Dwight M. Frost, M.D., Medical Director, 600 Doctors Building, Omaha, Nebraska (5).

Wanted: Occupational therapists, men and women, for a full approved, large psychiatric hospital in New England, midway between New York and Boston. Active in teaching and research. Large, new occupational therapy center, "the building of tomorrow." New and modern equipment, dynamic all-inclusive treatment program for patients. Large affiliating student group with excellent education program. Modern home, maintenance optional. Liberal retirement plan and illness policy. Paid vacations and holidays, automatic increments. Rotating services which offer professional growth.

Immediate appointments, Write: Harry Kromer, O.T.R., Norwich State Hospital, Norwich, Connecticut.

Challenging positions available for OTR's in New Jersey's largest state mental hospital with opportunity available for professional growth. Progressive, well equipped department under direction of Mrs. Lucille Boss, O.T.R. Staff conferences, excellent guidance. Staff salary $4200-$5100, Sr. $4360-5460. Full maintenance approximately $400 annually. Apply Personnel Department, New Jersey State Hospital, Greystone Park, N. J., (approximately 30 miles west of New York City—near Morristown, N.J.)

Immediate opening for occupational therapist, with degree. Special school for physically handicapped. Cerebral palsy experience desirable. Apply, Mrs. Andrew Witengier, Coordinator of Medical Services, Forrest Park School, 1600 Silver Star Road, Orlando, Florida.

Excellent opportunities for occupational therapists to use knowledge and abilities in developing a progressive, dynamic program. Located in suburban Louisville, Kentucky, which offers educational and cultural advantages. Starting salary per year $4296, 40 hour week, paid vacation and sick leave, 13 holidays per year, opportunity for advancement to supervisory positions. Contact Miss Margaret Biener, Director of O.T., Central State Hospital, Lakeland, Kentucky.

Assistant director, modern tuberculosis hospital with affiliation program. Close liaison with active state rehabilitation program. Patient rehabilitation conferences with heads of professional services. Five-day, 40-hour week, paid vacations, 7 holidays, sick leave, social security. Excellent opportunity for progressive administrator. Send resume to Mrs. May Yokoyama, Director, Occupational Therapy, Emily P. Bissell Hospital, 3000 Newport Gap Pike, Wilmington 8, Delaware.

Occupational therapist, registered, staff level; interested in working with amputees, polios, paraplegics, cerebral palsy and related diagnoses. Rehabilitation hospital with present bed capacity of 65 beds. Planning now underway for expansion of in-patient and out-patient facilities. Progressive personnel policies. Salary commensurate with experience and training. Apply Administrator, Eastern N.Y. Orthopaedic Hospital-School, Inc., 124 Rosa Road, Schenectady 8, New York.

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Administrative Assistant

Immediate openings for registered occupational therapists and graduates of approved schools eligible for registration, in 2000 bed chronic disease hospital affiliated with New York Medical College. Positions available in children's rehabilitation (primarily cerebral palsy), adult rehabilitation, and ward program. Five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit. Salary $3750-4830. Write Mrs. Carolyn Aggarwal, O.T.R., Bird S. Coler Hospital, Welfare Island, New York 17, N. Y.

Wanted: Staff occupational therapist for the Suburban Cook County Tuberculosis Sanitarium District, Hinsdale, Illinois (suburb of Chicago). Expanding program, 225 bed hospital. New OT shop. Starting salary $4200-4500, dependent on experience. Two weeks vacation, 12 days sick leave, 11 holidays, plus other employee benefits. Maintenance available. Write to: Miss Ellen Harenburg, O.T.R., 55th & County Line Road, Hinsdale, Illinois.

Immediate opening for occupational therapist, registered or eligible for registration. Acute intensive treatment psychiatric hospital with student affiliation, research and teaching programs. Located in large university medical center. Modern recreational facilities available. Salary range $4020 to $6300; beginning salary commensurate with experience. Contact Virginia L. Caskey, O.T.R., Coordinator of Activity Therapy, Larue D. Carter Memorial Hospital, Indianapolis 7, Indiana.

Wanted: occupational therapist for children's convalescent hospital. Live in. 5 day week. Semi-yearly increments, social security. Apply Superintendent, Betty Bacharach Home, Longport, N. J. (Atlantic City).

Georgia Warm Springs Foundation

GRADUATE COURSE

Physical Therapy and Occupational Therapy

In the Care of *Neuro-Muscular Disease*

This course is open to graduates of approved schools of physical and occupational therapy. Such graduates must be members of the American Physical Therapy Association and/or American Registry of Physical Therapists, or American Occupational Therapy Association.

Entrance dates: First Monday in January, April and October.

Course I—Emphasis on care of convalescent neuromuscular disease with intensive training in functional anatomy, muscle testing, muscle reeducation and use of supportive and assistive apparatus. This course is complete in itself.

Course II—Three months duration with course I prerequisite. Emphasis on care of severe chronic physical handicaps with intensive training in resumption of functional activity and use of adaptive apparatus.

In-Service Training Program—Fifteen months duration at salary of $225 per month plus full maintenance, increasing to $250 per month at the completion of nine months. This program includes training in course I and II.

Tuition: None. Maintenance is $100 per month. For scholarship to cover transportation and maintenance for course I and II, contact National Foundation for Infantile Paralysis, Inc., 301 East 42nd St., New York 17, N. Y. (Scholarships require two years of experience.)

For further information contact:

ROBERT L. BENNETT, M.D.
Medical Director

Georgia Warm Springs Foundation
WARM SPRINGS, GEORGIA

Eastern State Hospital, Medical Lake, Washington, has received authorization for additional positions. Hospital is moving from custody orientation to therapy orientation in all areas. Additional occupational therapy personnel now authorized, 23. Vacant position for director of department, senior and junior therapists and occupational therapy aides. O.T.R. salary range from $4368 to $6732 depending on qualifications and experience. Apply G. Lee Sandritter, Superintendent, Eastern State Hospital, Medical Lake, Washington.

Occupational therapist wanted, preferably male though not essential, to head well established department in rehabilitation center. Physical disabilities treated. Combination out-patient and home service program. Newly expanded facilities excellently equipped to offer functional treatment, ADL and pre-vocational services. Salary open. Liberal personnel policies. Write C. Margaret Gleave, Executive Director, the Curative Workshop of Racine, 2335 Northwestern Avenue, Racine, Wisconsin.

Wanted registered occupational therapist out-patient rehabilitation center. Inquire Half Way House, 12 E. Boulder, Colorado Springs, Colorado.

Registered occupational therapist for permanent position in modern 250 bed general hospital. Northeast Ohio area. Primary duties would be in connection with orthopedic department known as Gates Hospital for Crippled Children. Write Personnel Director, Elyria Memorial Hospital, Elyria, Ohio.

Supervisory position in new 120 bed rehabilitation unit for occupational therapist with rehabilitation experience. Position open after January 1, 1959. Apply Personnel Director, Iowa Methodist Hospital, Des Moines, Iowa.

Immediate opening for registered occupational therapist to direct OT program carrying the responsibility of a central shop area as well as the ward shop activity. Included, also, will be the development of a student affiliation program. Living quarters available, two weeks' paid vacation, sick leave. Beginning salary range $3,780-$4,560. Contact Bennett A. Kroeck, O.T.R., Co-ordinator of Adjunctive Therapies, Apple Creek State Hospital, P.O. Box 148, Apple Creek, Ohio.

Wanted: occupational therapist with at least 5 years experience, to take charge of occupational therapy program in a home for aged under supervision of well known physiatrist. Will work with medical rehabilitation team. Personnel practices follow those of Association. Apply: Mr. A. Deskin, Executive Director, Montreal Hebrew Old People's Home, 4374 Esplanade Ave., Montreal 18, Quebec.

Open immediately, position of chief of occupational therapy at Parkland Memorial Hospital. Connected with Southwestern Medical School and Texas Woman's University School of Nursing. Need therapist experienced in physical disability area to administrate 3 clinics with 5 sections consisting of pediatrics, general medicine and surgery, psychiatry, TB and physical disability. For further information write: Mrs. Jody King, O.T.R., Chief, Occupational Therapy, Parkland Memorial Hospital, 5201 Harry Hines Blvd., Dallas 35, Texas.

One staff and one senior staff position in a residential school for cerebral palsied children. Open to registered therapists. Salary range from $3700 to $4500 depending upon position and experience. 44 hour work week. University affiliations. Fringe benefits. Southern resort town offering year round outdoor sports. Contact: Miss Robertine St. James, Superintendent, Moody State School, Box 420, Galveston, Texas.

OCCUPATIONAL THERAPISTS
& SUPERVISORS
urgently needed by
WASHINGTON STATE
DEPARTMENT OF INSTITUTIONS

Rewarding opportunities are offered to occupational therapists eligible for registration by the American Occupational Therapy Association, in a new, progressive, vital mental health treatment program. Several new positions now exist in mental hospitals and schools for retarded children throughout the state. In addition to the usual prerequisites of paid leave, holidays, and retirement, these merit system positions offer federal social security plus these liberal salaries:

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SR. OCCUPATIONAL THERAPIST ..... $4764-5652 yr.

OCCUPATIONAL THERAPIST.. $4368-5184 yr.

For further information and applications contact: Washington State Personnel Board, 212 General Administration Building, Olympia, Washington.

Immediate opening, supervising OT with experience, new dynamic rehabilitation program in community Chronic Disease Institution, state rehabilitation agency patients also treated. Must administer and plan program with other members of rehabilitation team. New air-conditioned well equipped department. Salary $5200 to start. Pension, free life insurance, other liberal personnel policies. Maintenance on grounds optional. Write Bertram M. Bernstein, M.D., 606 Sanhican Drive, Trenton 8, N. J.

Occupational therapy director, salary $4704 per year to $5880. Occupational therapist, salary $3456 per year to $4320. 4600 bed state mental hospital. All state benefits including liberal sick leave, vacation, and 11 paid holidays. Hospital is currently being remodeled and expanded. Apply Personnel Office, Central State Hospital, Petersburg, Virginia.

Occupational therapist—registered, staff level, 600-bed tuberculosis hospital for the District of Columbia, J.C.A.H.; active rehabilitation program; salary $4,040 to $4,980; room $13.00 month; 8-hour 5-day week; vacation 104 hours per year, 160 hours after 3 years' service; hospital located 15 miles from center of Washington, D. C.; sick leave; retirement; insurance and other fringe benefits available. Write to: Moe Weiss, M.D., Superintendent and Medical Director, Glenn Dale Hospital, Glenn Dale, Maryland.

Occupational therapist staff position, preferably some experience in cerebral palsy. Outpatient center, all ages, offering physical therapy, occupational therapy, speech therapy and special education. Some student training program. Annual four weeks paid vacation. Hours: 8:30 to 4:00, Monday through Friday. Salary open. Apply: Miss Modenna M. Brossard, R.P.T., Coordinator, 502 W. Mistletoe Avenue, United Cerebral Palsy Treatment Center, San Antonio, Texas.

Wanted: industrial therapist, man or woman, must be O.T.R. with 1 year of experience. 2 occupational therapists to manage OT shops in expanding program. Research program now underway, looking forward to student affiliation program soon. Attractive university town in mountain and lake setting. Salary range $340 to $415 monthly. Social security. Please write for details: Mrs. Alice H. Peden, O.T.R., Director of Rehabilitation Therapies, Utah State Hospital, Provo, Utah.

Wanted immediately: O.T.R. for expanding ward program in tuberculosis hospital. Laundry, meals, paid vacation and sick leave, hospitalization and retirement benefits, salary open, no experience necessary. Cooperative staff relationships, good budget. Near Smoky Mountains and University. Apply: Mr. Robert M. Gleason, Business Administrator, East Tenn. Tuberculosis Hospital, Tazewell Pike, Knoxville 18, Tenn.

Registered occupational therapist with at least two years experience, preferably in cerebral palsy or physical disabilities. Direct department in hospital-school for physically disabled children, in and out patients, neuromuscular and orthopedic conditions. Coordinated program among OT, PT, speech and education. New department with home training, ADL, functional activities. Recreation facilities, three three-week vacations per year; salary $4500 and up depending on experience. Write Mr. Keith Newcomb, Principal, Crippled Children's Hospital and School, Sioux Falls, South Dakota.

Registered OT wanted for small hospital-school for cerebral palsied and other crippled children. Excellent working conditions and hours. Salary open. Apply Director, Mississippi Hospital-School for Cerebral Palsy, P.O. Box 4663, Jackson 6, Mississippi.

Immediate openings for registered occupational therapists and graduates of approved schools for registration. One experienced therapist and two junior therapists needed for 2½ year research study of the rehabilitation potential of nursing home population. Liberal benefits. Salary $4,000 to $5,000. Write to Dr. Lawrence I. Kaplan, Medical Director, Nursing Home Project, Department of Physical Medicine and Rehabilitation, New York Medical College, 1 East 105 Street, New York, N. Y.

Registered occupational therapist for staff position, cerebral palsy department. Salary $4,300-$5,310. Excellent working conditions and fringe benefits. Write: Lavinia M. Davidson, Director CP Dept., New York State Rehabilitation Hospital, West Haverstraw, N. Y.

O.T.R. position available in November to work with preschool cerebral palsied children under the direction of an experienced therapist; comprehensive treatment and school program; 35 hour week, one month vacation. Write: Administrator, Spastic Children's Clinic & Preschool, 1850 Boyer Ave., Seattle 2, Washington.

O.T.R. Immediate placement. $4,440-$5,400, depending on training and experience. Permanent appointment Minnesota Civil Service. Ten-year research project involving pre-discharge planning and community follow-up of discharged mental hospital patients. Occupational therapist cooperates in working out discharge plan for individual patient. Sets up OT plan both in hospital and recommended plan to be carried out in community. O.T.R. should be familiar with mental hospital surroundings and have some understanding of all rehab therapies. Duties include collecting of data, standardizing reports and evaluating patients' performance. Joseph C. Lagey, Ph.D., Project Director, Moose Lake State Hospital, Moose Lake, Minnesota.

Wanted: O.T.R. for cerebral palsy foundation. Salary open, five (5) day week, one (1) month paid vacation after one year of service, paid holidays, lunch, uniforms, laundry, employee benefits (social security, Blue Cross, Blue Shield), established, well equipped department, air conditioned, pleasant working conditions in a progressive gulf coast city of 140,000 population. Contact (Mrs.) Margaret L. Snyder, Cerebral Palsy Foundation, 1350 Broadway, Beaumont, Texas.

Experienced, registered OT, head of occupational therapy program in 65-bed specialized children's hospital; suburban Oklahoma City; supplemental facility to University of Oklahoma Medical Center and Children's Memorial Hospital. OT student affiliate program agreement with University of Kansas and Colorado State University. Good salary, well above median for Southwest; annual and merit increases; paid vacation and sick leave; excellent retirement plan. Participation in state and national association activities encouraged; time off with pay, allowance on expenses for professional conferences or conventions. Address: Administrator, Children's Convalescent Hospital, Box 698, Bethany, Oklahoma.

Registered occupational therapist mainly servicing pediatric and convalescent clinic and hospital patients. The opportunist will find challenging work, exceptional facilities, outstanding employee benefits and a warm family welcome. Apply Personnel Director, The Cleveland Clinic Foundation, 2020 E. 93rd St., Cleveland 6, Ohio.

Immediate openings for two staff occupational therapists and one supervisory opening in progressive psychiatric center associated with the medical school of the University of Michigan, in the children's psychiatric hospital, and for intensive treatment of children, adolescents, and adults with occupational and recreational therapy supervisors on each unit. Student affiliation center. Qualifications: B.S. degree, O.T.R. Generous personnel benefits, salary commensurate with experience. Address communications to the Personnel Department, University Medical Center, University of Michigan, Ann Arbor, Michigan. Wanted as soon as possible.

Immediate placement for registered, qualified occupational therapists in rapidly expanding physical medicine and rehabilitation institute serving two hospitals, total 1,000 general medical and surgical beds, in largest centrally located industrial center in Illinois. Experience in supervisory position and in comprehensive rehabilitation center necessary. Write: Administrator, Institute of Physical Medicine and Rehabilitation, 619 North Glen Oak Avenue, Peoria, Illinois.

Position open—staff therapist—OT I level—$4316-$5512—at Clarks Summit State Hospital, Clarks Summit, Penna. Apply: Dr. Ralph Archer, M.D., Superintendent.

Staff O.T.R.—challenging program in total rehabilitation of psychiatric patient. Complete maintenance $40.00, 2 weeks vacation, liberal sick and retirement benefits, civil service, 40 hr. week, $4100-$5000. Hospital located in capital city. Write Mr. Miller, O.T.R., Oregon State Hospital, Salem, Oregon.

Rehabilitation services program needs graduate OT's, eligible for later registration. Experience not necessary. Professional growth and satisfaction guaranteed. Excellent starting salary, pension, liberal holidays, vacation and sick leave. Apply for immediate employment to Mr. Stanley Doenecke, Director, Rehabilitation Services, Tuberculosis Hospital, Oak Forest, Illinois.

Qualified occupational therapist with experience, to work as member of medical team in 900 bed teaching hospital affiliated with Western Reserve University. Supervisory opening in tuberculosis section expanding into area currently under construction. Five-day week, paid vacation and sick leave, meals, room, and laundry available at minimal cost. Salary dependent upon qualifications. Pension plan. Apply: Nadene Coyne, M.D., Director, Dept. Physical Medicine & Rehabilitation, Cuyahoga County Hospital (formerly City), 3395 Scranton Rd., Cleveland, Ohio.

Registered occupational therapist needed for our newly equipped branch of service. Will be in full charge of work. Term of contract ten and one half months. Hours nine to four o'clock. Salary $4500. Apply to Mrs. D. A. MacGregor, Executive Director, Wheeling Society for Crippled Children, 1316 National Rd., Wheeling, W. Va., for details.

Occupational therapists for California state hospitals. Progressive program presents opportunities for imaginative, resourceful therapeutic activities. O.T.R. works as member of professional team toward goal of total rehabilitation of the individual patient. No experience required to start at $376; promotions possible to $644. Three weeks paid vacation annually and other employee benefits. Write State Personnel Board, 801 Capitol Avenue, Sacramento, California.

Occupational therapist—to initiate OT program in private 272 bed hospital. Salary open; one year experience desirable. Apply: Ivan Kline, Chief PT, Baptist Memorial Hospital, Jacksonville, Florida.

Staff occupational therapist for cerebral palsy school-clinic in Atlanta. Day School program, clinic and outpatient services for 100 children ranging in age from 18 months to 17 years. Five-day work week, public school holidays, 2 weeks summer vacation, sick leave, salary open. Send qualifications and work summary to: Mrs. Harold M. Seymour, Administrator, the Cerebral Palsy School-Clinic of Atlanta, Inc., Atlanta 7, Ga.

Qualified OT for well-equipped out-patient treatment center with Crippled Children's Society. Liberal salary, one month's vacation. Write Mrs. Robert E. Everhart, Ex. Secy., Lycoming County Crippled Children's Society, 625 W. Edwin St., Williamsport, Pa.

Wanted: registered occupational therapist to organize new service program for chronically handicapped and mentally retarded. Salary open for discussion. Apply to Beloit Visiting Nurse Ass'n., Beloit, Wisconsin.

We are looking for an experienced girl in occupational therapy, psychiatric division of the Philadelphia Psychiatric Hospital. Salary—$4,300 to start. Please contact Mrs. Kathryn K. O'Brien, O.T.R., Philadelphia Psychiatric Hospital, Ford Road & Monument Avenue, Philadelphia 31, Pa., for further information.

Immediate opening for occupational therapists in world-famous university hospital. Programs in psychiatry, G M & S, physical disabilities. Write Mary K. Joss, Chief, Occupational Therapy Dept., The Johns Hopkins Hospital, Baltimore 5, Md.

Occupational therapist: Medically supervised program geriatric rehabilitation. Salary range $4320-$4960 in two years. Liberal personnel policies. Maintenance available. 5 day, 40 hour week. Must be graduate of accredited school. Contact Westchester County Home, 25 Bradhurst Avenue, Hawthorne, N. Y. LYric 2-8300.

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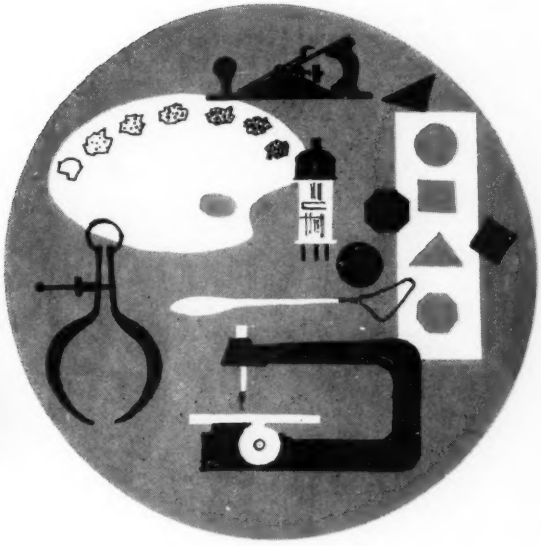

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the Program —An AMSC-sponsored Occupational Therapy Clinical Affiliation, enabling you to qualify as an occupational therapist without financial worry. Approved by the Council on Medical Education and Hospitals of the American Medical Association, this affiliation program can include the following: clinical application of occupational therapy in the treatment of patients with physical disabilities (12 weeks); neuropsychiatric disorders (12 weeks); general surgical and medical conditions (4-8 weeks); tuberculosis (4-8 weeks). The length and type of affiliation program is determined by the director of the approved school of occupational therapy, and the affiliation is conducted in outstanding Army teaching hospitals. Upon entering the program, you will be commissioned a Second Lieutenant in the AMSC, Army Reserve, and will receive $222.30 per month plus $47.88 monthly subsistence and quarters. In addition to enjoying the rank, pay and prestige of an Army officer, you will have a 30-day vacation with pay every year. After completing your affiliation, you will be assigned as a staff member in an Army hospital, working with other officers in an outstanding professional career.

the Qualifications —Applications are accepted from: (1) occupational therapy students who are completing the required four-year course; or (2) candidates who possess a bachelor's degree and are enrolled in an approved course in occupational therapy. Applications are accepted for this program from October to May. Affiliations begin each fall.

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